STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☒ Reverse Accident	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Robert Monroe,

Petitioner,

vs. NO: 11 WC 46174

Department of Transportation/ State of Illinois,

14IWCC0381

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, temporary total disability and permanent disability and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below.

The Commission finds that Petitioner failed to prove that he sustained accidental injuries arising out of and in the course of his employment.

Petitioner testified that he was an accountant for the Illinois Department of Transportation. His job consisted of making payments for all the contracts that come in on that particular day. These contracts are split up between him and other accountants. He would also look at and break down award notices making sure they are proper. He would also look at the contracts and make sure everything was proper on them. (Transcript Pgs. 8-11)

He further testified that he uses both his hands all day long while at work. He is always flipping through pages and typing on the computer. On slow days he works with around 30 contracts and busy days he works on up to 65. A typical contract would be 30 to 60 pages. (Transcript Pgs.11-14)

Petitioner also claimed that his keyboard was at the very back of his desk and that he had his elbows on the desk toward the very edge. The contracts and award notices were between him and the keyboard. Petitioner testified that he would flip the pages of the contracts with his elbows resting against the edge of his desk. (Transcript Pgs. 14-15)

However, the Commission finds the Petitioner's testimony less than credible.

On cross examination Petitioner admitted that when he reviewed award notices he would go from computer screen to computer screen. He did not input into the computer. He also testified that he does the same with contracts. He does fill in the blanks on the computer and every contract has at least two blanks. Sometimes with certain road contracts he has to type in a whole sentence. Sometimes with new contracts he has to input the actual pin numbers and take out the punctuation. He has to input at least 3-5 words. (Transcript Pgs. 30-32)

In regards to COD's he would just print them out using the mouse. He doesn't write them but just checks them to make sure all the information is correct. He works on about 30 COD's a day. (Transcript Pgs. 33-35)

Petitioner, during his Independent Medical Exam with Dr. Williams on April 25, 2012, told the doctor that his keyboard was two feet from the front of his desk. The Respondent's attorney placed a keyboard two feet away from Petitioner and Petitioner admitted he may have been wrong with the distance he told Dr. Williams. Petitioner then placed the keyboard where he believed it should have been and it was about one foot away from his desk. (Transcript Pgs.38-40)

Dr. Williams testified if Petitioner has his wrist resting on the table and he is typing, that could potentially aggravate the condition. However, it is impossible to do that and have your forearm resting against the table. Petitioner never stated to him or any other doctors that he ever rested his wrists on the table. It is possible, with the keyboard 2 feet away from him that he could rest his wrists and type. However, if he does that he is not putting pressure on his forearms. He is not resting his forearms on the edge. It is very important that it is the edge and not just the table which is flat and smooth. (Respondent Exhibit 3 Pgs. 75-81)

In Dr. Borowiecki's, Petitioner's treating doctor, September 16, 2011, office note he states "He is pretty adamant about the fact that he does not spend a lot of time with the arm resting against any type of arm rest, table or desk edges, et cetera." However, this has no impact on his opinion that the carpal or cubital tunnel was caused by the use of an arm rest. (Petitioner Exhibit 2 Pg. 42-43)

In Dr. Borowiecki September 20, 2011, letter he indicates that Petitioner faxed a list of activities that he does that tend to worsen his numbness and paresthesias. According to the fax Petitioner does a fair amount of typing, turning pages and contract writing. He lifts stacks of contracts and papers, uses an adding machine, types emails and generally does most of his work on a computer keyboard. This aggravates his symptoms. He positions his keyboard on the back of his desk and has no place to get the keyboard lower to avoid pressure on the ulnar aspects of his forearm. The purpose of the letter was to document Petitioner's work activities do aggravate his cubital tunnel symptoms. (Petitioner Exhibit 1)

The Commission finds that Dr. Borowiecki's testimony is flawed because the Petitioner did not give him accurate information regarding his job duties.

Melissa Doedtman, the Contact Administration Manager in the Bureau of Construction, testified she oversees various units, one of which the Petitioner is a member of. The information contained on the contracts comes from someplace else. Petitioner is just verifying the information. In some instances there will be changes like the name of the company or an address, but typically most of the information is there. The changes that are made are minimal. There are some contracts that are still in paper form and the quantities have to be inputted into the database. These are numerical and are normally done with a keypad. Each contract could have 10 -80 payments but these are made during the life of the contract. If it is a new item Petitioner would be typing a short description of those items into the database. The database field for these new items is 18 characters long. The text of the contracts is not generated in her office and the pay estimates are also generated offsite. (Transcript Pgs. 66-70)

Ms. Doedtman indicated that Petitioner would review 30 contracts per day and in the summer it could be up to 300. However, Petitioner would not have to turn every page of the 200-300 page contracts. There may be only 4 to 5 places within a contract that Petitioner will have pieces of information he has to verify. (Transcript Pgs. 72-73)

The Commission finds the testimony of Ms. Doedtman credible.

The Petitioner's job duties at work were not repetitive and did not exacerbate or aggravate his bi-lateral carpal and cubital tunnel condition. Therefore, Petitioner has failed to show that he sustained injuries arising out of and in the scope of his employment.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision filed with the Commission on May 7, 2013, is reversed and a finding that Petitioner failed to prove he sustained accidental injuries that arose out of and in the course of his employment with Respondent be substituted in its place.

DATED: MAY 2 7 2014

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

CJD/hf
O: 3/26/14
049

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MONROE, ROBERT
Employee/Petitioner

Case# **11WC046174**

14IWCC0381

ST OF IL/DEPT OF TRANSPORTATION
Employer/Respondent

On 5/7/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

4553 JACK DAVIS LAW OFFICES LLC
GREGORY W SRONCE
319 E MADISON ST SUITE 2C
SPRINGFIELD, IL 62701

0502 ST EMPLOYMENT RETIREMENT SYSTEMS
2101 S VETERANS PARKWAY*
PO BOX 19255
SPRINGFIELD, IL 62794-9255

4390 ASSISTANT ATTORNEY GENERAL
ERIN DOUGHTY
500 S SECOND ST
SPRINGFIELD, IL 62706

0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST
13TH FLOOR
CHICAGO, IL 60601-3227

1430 CMS BUREAU OF RISK MGMT
WORKERS COMPENSATION MANAGER
PO BOX 19208
SPRINGFIELD, IL 62794-9208

CERTIFIED as a true and correct copy
pursuant to 820 ILCS 305/14

MAY 7 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

14IWCC0381

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

- ☐ Injured Workers' Benefit Fund (§4(d))
- ☐ Rate Adjustment Fund (§8(g))
- ☐ Second Injury Fund (§8(e)18)
- ☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

ROBERT MONROE
Employee/Petitioner

v.

STATE OF ILLINOIS – DEPT. OF TRANSPORTATION
Employer/Respondent

Case # 11 WC 46174

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brandon J. Zanotti**, Arbitrator of the Commission, in the city of **Springfield**, on **March 8, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On **June 8, 2011**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned **$42,685.76**; the average weekly wage was **$820.88**.

On the date of accident, Petitioner was **40** years of age, ***married*** with **0** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**.

Respondent is entitled to a credit for all medical bills paid by it pursuant to Section 8(j) of the Act.

ORDER

Respondent is liable for payment of medical bills relating only to Petitioner's bilateral cubital tunnel and left carpal tunnel treatment from June 14, 2011 through January 24, 2013, as contained in Petitioner's Exhibit 3, subject to the medical fee schedule, Section 8.2 of the Act. Respondent shall have any and all appropriate credit for any amounts paid by it or its group insurance carrier.

Respondent shall pay Petitioner permanent partial disability benefits of $492.53/week for 71.1 weeks, because the injuries sustained caused the 10% loss of both arms, and the 10% loss of the left hand, as provided in Section 8(e) of the Act.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

05/02/2013
Date

MAY - 7 2013

STATE OF ILLINOIS)
)SS
COUNTY OF SANGAMON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

ROBERT MONROE
Employee/Petitioner

v. Case # 11 WC 46174

STATE OF ILLINOIS – DEPT. OF TRANSPORTATION
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner, Robert Monroe, testified that he has been employed with Respondent, the State of Illinois Department of Transportation, for three years. He has been employed by the State of Illinois for a total of eight years. During that time period he has held the position of an accountant. Petitioner described his duties in his testimony. Petitioner testified that he works 7.5 hour days, 5 days per week. He testified that he "handles" all incoming road construction contracts in the State of Illinois. In the mornings, he makes payments on all the contracts for that day. He then breaks down the award notices and makes sure they are proper. He then reviews all contracts to make sure they are in proper order. If time permits in a day, he then makes final preparations on the contracts to be sent to the Comptroller's office. He also testified that his job intensifies with more contracts needing reviewed, especially during the summer months. He testified that he processes about 30 contracts per day on a "slow" day, and up to 65 contracts per day on a busy day in the summer. He explained that the summer months are busier because that is when most road construction is being performed.

Petitioner testified concerning the ergonomic configuration of his work station. He testified that his keyboard was placed on top of his desk for the entire period of his employment. He testified that he uses a keyboard for data entry, which is placed far enough away from the edge of the desk to allow a contract to rest between the edge of the desk and his keyboard. Petitioner testified that as he enters data, his left and right elbows are resting on the edge of the desk. He also described using his left hand for "turning the pages" of contracts while reviewing the same for accuracy. He testified that he engages in this document review and data entry regularly and that he turns pages and enters data the majority of the work day. Petitioner testified that during his typing activities and turning pages, he has his wrists/hands "flexed" in an upward position. Petitioner's Exhibit 4 is a document which sets forth Petitioner's job duties. This exhibit comports with Petitioner's description of his job duties. (See Petitioner's Exhibit (PX) 4). Of note is the fact that the job description (called a "Demands of the Job" form) indicates that

Petitioner's job requires him to use his hands for "fine manipulation" and "gross manipulation" six to eight hours per day. Petitioner's direct supervisor, Karen Higdon, signed and initialed this document.

Petitioner testified that on and before June 8, 2011, he began to experience pain, numbness and tingling in his left hand, left arm and right arm. He testified that prior to this time, while he did have a right carpal tunnel release that was settled with Respondent, he had not experienced any injury or trauma to his left hand, left arm, or right arm. Petitioner testified that he was in good health, and continued to be in good health with respect to his left wrist, left arm and right arm prior to experiencing these symptoms. While the issue of "notice" is not in dispute in this claim, the Arbitrator notes that Petitioner submitted a "Notice of Injury" form which contains a description of Petitioner's condition and onset of symptoms that comports with Petitioner's testimony at trial in this claim. (See PX 5).

On June 14, 2011, Petitioner sought treatment from Dr. Tomasz Borowiecki at Springfield Clinic as a result of experiencing pain, numbness and tingling in his left wrist and bilateral elbows. On that date, Petitioner described his symptoms of pain, numbness and tingling to Dr. Borowiecki. Specifically, it was reported that Petitioner "notices this mainly when he is working on a computer or at a desk, resting his forearms on the edge of the counter or table." (PX 1). Dr. Borowiecki's evaluation of Petitioner on June 14, 2011 concluded with findings and complaints consistent with cubital tunnel syndrome and left carpal tunnel syndrome. (PX 2, p. 16). At this time, Dr. Borowiecki ordered a nerve conduction study. (PX 1).

On August 8, 2011, Petitioner underwent an EMG conducted by Dr. Cecile Becker at Springfield Clinic. The results of that EMG were negative. (PX 1).

Petitioner saw Dr. Borowiecki again on August 18, 2011 for a follow up evaluation. At this visit, Petitioner's symptoms of numbness, tingling and pain in his left hand and bilateral arms had persisted. Despite the negative EMG findings, Dr. Borowiecki diagnosed left carpal tunnel syndrome and cubital tunnel syndrome. He based this diagnosis, in part, on positive examination findings (Tinel's and compression tests). (PX 1). His note states as follows:

> "Dr. Becker had done nerve studies on the patient, and she did not find any abnormalities at all on either side, which I am a little bit perplexed by, as clinically the patient certainly has evidence of carpal tunnel on the left and cubital tunnel-type symptoms on the right."

(PX 1).

In light of the foregoing opinions, Dr. Borowiecki recommended repeat electrodiagnostic studies to be performed by a different neurologist. On November 4, 2011, Dr. David Gelber at Springfield Clinic administered an updated EMG nerve conduction study, which confirmed Dr. Borowiecki's clinical diagnosis of bilateral cubital tunnel syndrome/ulnar neuropathy at the elbow. (PX 1; PX 2, p. 18). The EMG revealed no evidence of carpal tunnel syndrome. (PX 1). On November 8, 2011, Dr. Borowiecki discussed with Petitioner that surgery was an option for both arms. At that time, Petitioner elected to continue with observation. (PX 2, p. 24).

On February 2, 2012, Petitioner was referred to Dr. Mark Greatting, who is an upper extremity specialist at Springfield Clinic. Dr. Greatting began treatment for a left shoulder rotator cuff tear issue Petitioner experienced, which is not a part of the present claim. (See PX 1). Petitioner also underwent

treatment for right carpal tunnel syndrome (see PX 1), which is not a part of this claim and in fact was settled with Respondent, as mentioned *supra*.

Petitioner presented to Dr. Borowiecki on August 16, 2012, reporting hand numbness and bilateral elbow numbness and tingling. Dr. Borowiecki's impression was as follows: "Left carpal and cubital tunnel syndrome, failing conservative management as well as right cubital tunnel syndrome." Petitioner reported to Dr. Borowiecki on this date that he wanted to proceed with the bilateral cubital tunnel and left carpal tunnel surgeries. (PX 1).

On October 3, 2012, Dr. Borowiecki performed a left carpal tunnel release and a left ulnar nerve submuscular transposition for cubital tunnel syndrome. On December 5, 2012, Dr. Borowiecki performed a right ulnar nerve exploration and submuscular transposition for Petitioner's right cubital tunnel. (PX 1).

Petitioner presented for a post-operative follow-up evaluation concerning his left cubital and carpal tunnel surgeries with Dr. Borowiecki on October 25, 2012. On that date, it was reported concerning Petitioner's left arm/wrist that "the numbness has resolved except at the very tips of the middle and ring fingers where he still feels a little numbness persisting but things continue to improve." (PX 1).

Petitioner testified that he had been diagnosed and treated for other conditions prior to June 8, 2011, including psoriasis approximately 20 years ago when he presented at a VA Hospital. In addition, Petitioner testified that he has been diagnosed with sleep apnea, plantar fasciitis, and torn cartilage in his knee.

On November 20, 2011, Dr. Borowiecki opined as to causation of Petitioners symptoms in a letter, stating:

> "[Petitioner] does a fair amount of typing, turning pages and contracts writing, lifting stacks of contracts and papers, using an adding machine, typing emails and generally doing most of his work on a computer keyboard. He states all of these activities aggravate his symptoms. He does position the keyboard on the back of his desk so that he has space to work. He has no place to really get the keyboard a little bit lower to avoid pressure on the ulnar aspects of his forearms, according to patient. Again, this is simply to document that the patient's work activities do aggravate his cubital tunnel symptoms."

(PX 1; PX 2, pp. 28-29).

Dr. Borowiecki's deposition testimony was taken on February 16, 2012. Dr. Borowiecki is a board certified orthopedic surgeon. (PX 2, Dep. Exh. 1). Dr. Borowiecki testified, to a reasonable degree of medical certainty, that Petitioner's bilateral cubital tunnel syndrome and left carpal tunnel syndrome could cause to become symptomatic or be aggravated by his duties of employment as an accountant with Respondent. (PX 2, pp. 30-32). The following exchange took place between Petitioner's counsel and Dr. Borowiecki during the doctor's deposition:

Q. Can we agree that any opinions you render will be given to a reasonable degree of medical and surgical certainty?

A. Yes.

Q. Do you believe Mr. Monroe's bilateral cubital tunnel syndrome was caused to become symptomatic or aggravated by his duties of employment as an accountant with the State?

A. I believe that his duties he describes and the way he performs them certainly can aggravate cubital tunnel symptoms.

(PX 2, pp. 30-31).

****

Q. With regard to the left carpal tunnel syndrome, for which you have diagnosed Mr. Monroe, do you believe that his work duties at the State of Illinois caused or contributed to cause that condition to become symptomatic, sir?

A. ....He has it on the right side. I think it is very feasible that he has a subclinical, i.e., not diagnostic by nerve studies, but clinically causing symptoms and reproducible left carpal tunnel that are aggravated by his work activities.

(PX 2, p. 32).

Petitioner presented for an examination at Respondent's request pursuant to Section 12 of the Illinois Workers' Compensation Act, 820 ILCS 305/1 *et seq*. (hereafter the "Act") with Dr. James Williams on April 25, 2012. Dr. Williams reviewed Petitioner's medical records, including his right carpal tunnel syndrome records which are not a part of the claim at bar. Dr. Williams also reviewed various forms listing Petitioner's written job description and duties. Dr. Williams further conducted a physical examination of Petitioner. Dr. Williams' impression on the date of his examination was that of bilateral cubital tunnel syndrome and left carpal tunnel syndrome "despite negative EMG and nerve condition velocity testing or left median nerve neuritis." (RX 3, Dep. Exh. 2).

Dr. Williams reported that he did not believe Petitioner's job duties were aggravating or causative factors of his medical condition at issue. Dr. Williams' report further states: "The question is though if the patient truly rests his forearms around the elbow area on the medial aspect on the table as he states, this could obviously apply pressure over the ulnar nerve and could be an aggravating type issue to this problem." The doctor believed that Petitioner's bowling activities could at least be contributory and/or aggravating to his right-sided cubital tunnel syndrome. (RX 3, Dep. Exh. 2).

Concerning Petitioner's left carpal tunnel syndrome, Dr. Williams did not think it was aggravated by his work activities, and rather believed that condition could have been caused by "riding a motorcycle" and/or Petitioner's condition of psoriasis. Dr. Williams further reported the following: "At this point, I did find the patient to be honest and forthcoming. I did not find him to exhibit any evidence of symptom magnification or malingering." (RX 3, Dep. Exh. 2).

Dr. Williams' deposition testimony was taken on January 3, 2013. (RX 3). The following exchange occurred between Petitioner's counsel and Dr. Williams during the deposition regarding Petitioner's bowling activities:

Q. ...the illness or the injury of the left carpal tunnel, that wouldn't have anything do to with the bowling because he's right hand dominant, correct?

A. I agree with you, sir.

(RX 3 pg. 57).

Petitioner testified that he is an avid and very good bowler. Petitioner bowls in a league two to three nights per week. Three games are bowled on league nights. Petitioner testified that he throws a lot less than a bad bowler. His average is 235. At most, he will throw 16 balls in one game. As noted, *supra*, Petitioner is right hand dominant. When bowling, Petitioner's left hand is only used to help lift the ball. With his right hand, he testified that the act of bowling involves normal underhand movement, like that of a softball player. Petitioner testified that he does not ride a motorcycle, but rather rides a scooter. He has owned the scooter for three years, but testified he does not ride often. It is hard for him to ride it much due to his knee injuries, which are not a part of the claim at bar. Petitioner testified that when riding the scooter, his wrists are not in a flexed or extended position as he is "dead even" with the handle bars. He further testified that there is very little vibration when riding the scooter. A photograph of Petitioner's model of scooter that he identified at trial was entered into evidence as Petitioner's Exhibit 6.

Petitioner presented for a post-operative follow-up evaluation with Dr. Borowiecki on January 24, 2013. Dr. Borowiecki noted that Petitioner was "doing very well." The report also stated that Petitioner's "numbness is completely resolved" and that he had "regained full elbow motion." Dr. Borowiecki released Petitioner concerning the bilateral cubital tunnel and left carpal tunnel injuries on this date with no restrictions, and noted Petitioner could return on an as-needed basis.

Petitioner testified that following his bilateral cubital tunnel surgeries and left carpal tunnel surgery that he is "pain free."

Petitioner offered a series of medical bills into evidence as Petitioner's Exhibit 3. However, some of the charges in that exhibit are for treatment unrelated to the claim at bar. Further, that exhibit indicates that several payments were made from an insurance carrier.

CONCLUSIONS OF LAW

Issue (C): Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?; and

Issue (F): Is Petitioner's current condition of ill-being causally related to the injury?

Based on Petitioner's Demands of the Job form (which was not impeached as inaccurate by Respondent), Petitioner's credible testimony concerning his job duties and onset of symptoms that led to a diagnosis of bilateral cubital tunnel syndrome and left carpal tunnel syndrome that further led to surgeries to correct the same, and the causation opinions of treating orthopedic surgeon Dr. Borowiecki, the Arbitrator finds that Petitioner has proven that he sustained an accident that arose out of and in the course

of his employment with Respondent, and that his current condition of ill-being is causally related to that injury.

Respondent's examining physician, Dr. Williams, did not dispute the diagnoses of bilateral cubital tunnel syndrome, and in fact believed that it could have been aggravated by Petitioner's description of how he worked at his desk. Petitioner's testimony regarding his ergonomic situation at work was consistent with how he reported it to his treating physician and Respondent's examining physician. Dr. Williams believed Petitioner's hobby of bowling could have contributed to his cubital tunnel syndrome, but admitted that hobby would not affect the aggravation of his left carpal tunnel syndrome because Petitioner is right hand dominant. The Arbitrator also notes that no repetitive use of the left hand or left arm is required in bowling for a right hand dominant bowler like Petitioner, as per the testimony of Petitioner. Based on the evidence in the record, Petitioner's job duties were more likely to aggravate Petitioner's bilateral cubital tunnel syndrome than his bowling hobby.

Further, Dr. Williams did not believe that Petitioner's left carpal tunnel syndrome was aggravated by his work duties, but rather believed that condition was aggravated by Petitioner's "motorcycle" riding and psoriasis. However, Petitioner credibly testified that he does not ride a motorcycle, but in fact rides a scooter. Moreover, he rarely rides this scooter, and said his wrists are not in a flexed or extended position when he rides it. Further, Petitioner testified that the scooter does not cause much vibration. The evidence also indicates that Petitioner was diagnoses with psoriasis 20 years ago, and no real medical evidence was established to show that this condition aggravated Petitioner's cubital and carpal symptoms to the point where it negated his work duties as being causative factors thereof.

Petitioner testified that he has been diagnosed with sleep apnea, plantar fasciitis, and torn cartilage in his knee. However, the evidence does not indicate that any of those foregoing conditions would be considered aggravating factors of his bilateral cubital tunnel syndrome and left carpal tunnel syndrome.

The Arbitrator further finds that Petitioner was a very credible witness. His testimony was corroborated by the medical records in evidence. The Arbitrator notes that Petitioner consistently reported his symptoms and gave consistent reports of his work duties to his medical providers. Dr. Williams, Respondent's examining physician, even noted in his report that Petitioner was "honest and forthcoming." Petitioner openly testified in a forthcoming manner during cross-examination. He appeared to be endeavoring to tell the full truth during his entire testimony. The Arbitrator further finds Dr. Borowiecki's testimony to be credible, and adopts his causation opinions accordingly.

Issue (J): Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for reasonable and necessary medical services?

The Arbitrator finds that all treatment rendered to Petitioner concerning his bilateral cubital tunnel and left carpal tunnel symptoms is reasonable and necessary. Accordingly, Respondent is liable for payment of those medical bills relating only to Petitioner's bilateral cubital tunnel and left carpal tunnel treatment from June 14, 2011 through January 24, 2013, as contained in Petitioner's Exhibit 3, subject to the medical fee schedule, Section 8.2 of the Act. Respondent shall have any and all appropriate credit for any amounts paid by it or its group insurance carrier.

Issue (L): What is the nature and extent of the injury?

Petitioner suffered bilateral cubital tunnel syndrome and left carpal tunnel syndrome as a result of his work duties with Respondent. He underwent surgeries for the foregoing conditions, and was released with no restrictions after the surgeries with good results noted. He in fact testified at trial that he is now "pain free." No further testimony was given in regard to permanency. Having considered the evidence, and in light of the foregoing, the Arbitrator notes that the permanency award in this case should be lower than traditional awards regarding the same injuries, as Petitioner was released with no restrictions, good results were noted from surgery, and the only testimony concerning Petitioner's resulting condition of said injuries given was that he is now "pain free." The Arbitrator has considered the recent Commission decision of *Purdom v. State of Illinois – Menard Correctional Center*, 12 IWCC 1419 (Dec. 19, 2012) when determining the permanency awards. Based on the foregoing, the Arbitrator finds Petitioner has suffered permanent partial disability (PPD) to the extent of 10% to each arm, and 10% to the left hand, pursuant to Section 8(e) of the Act, and should be awarded PPD benefits accordingly.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael Gunderson,

Petitioner,

vs.

NO: 08 WC 38147

Weiss Memorial Hospital,

14IWCC0382

Respondent.

DECISION AND OPINION ON REVIEW UNDER SECTIONS 19(H) AND 8(A)

This claim comes before the Commission on a Petition for Review under Sections 19(h) and 8(a), filed by Petitioner on January 26, 2011. No question has been raised concerning the timeliness of Petitioner's 19(h) Petition. Commissioner White conducted a hearing in this matter on July 25, 2013. Petitioner and Respondent were represented by counsel and a record was made.

After considering the issues and being advised of the facts and the law, the Commission grants Petitioner's Petition for Review under Sections 19(h) and 8(a), finding that Petitioner proved a material increase in his work-related disability since the date of Arbitration and is entitled to additional permanent partial disability and temporary total disability benefits.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner, a 61-year-old stationary engineer who is right-hand dominant, sustained an undisputed work-related accident on August 8, 2008. On that day, Petitioner fell off of a ladder, fracturing his left wrist. Two days later, Petitioner underwent an open reduction and internal fixation. (Arb. Dec., 8/24/10)

2. On August 28, 2008 Petitioner filed an Application for Adjustment of claim for

work-related injuries to his left upper extremity.

3. Arbitrator DeVriendt conducted a hearing in Petitioner's claim on August 2, 2010. Petitioner testified that he had no left wrist problems prior to the date of accident. Following surgery, Petitioner returned to work with restrictions that were accommodated by Respondent. On October 21, 2008 he was released to return to full duty work and subsequently voluntarily left Respondent's employ to move to Arizona. He experienced ongoing pain in his left wrist, palm and back of the hand, made worse by driving, pushing and grasping. His last date of medical treatment was November 18, 2008 and he occasionally took Vicodin for pain. (Arb. Dec., 8/24/10)

4. The Arbitrator issued a decision on August 24, 2010, finding that Petitioner was entitled to temporary total disability benefits, unpaid medical expenses and permanent partial disability benefits of $664.72 per week for a period of 76.875 weeks, representing 37.5% loss of use of the left hand. (Arb. Dec., 8/24/10)

5. Neither party filed a Petition for Review within the statutory time limit and the decision of the Arbitrator became final.

6. At the §19(h) and §8(a) hearing on July 25, 2013, Petitioner offered medical records from Dr. Mahoney of the Brown Hand Center.

On September 28, 2010, less than two months after the arbitration hearing, Petitioner sought treatment with Dr. Stephen Mahoney at the Brown Hand Center in Phoenix, Arizona. Petitioner complained of left wrist pain that was as severe as it had been prior to surgery. Dr. Mahoney diagnosed left wrist osteoarthritis and opined that this was causally related to Petitioner's prior left wrist injury. Dr. Mahoney offered a course of steroid injections to decrease Petitioner's pain. Petitioner declined to have injections and wished to proceed with a left wrist fusion despite the expected outcome of a loss of range of motion. (PX 5) In order to ascertain the extent of the osteoarthritis Dr. Mahoney performed a diagnostic arthroscopy and partial synovectomy on December 3, 2010 at St. Michael's Surgery Center in Scottsdale, Arizona. (PX 6)

7. The parties appeared before Commissioner Lindsay on June 29, 2011. Petitioner sought authorization for left wrist fusion surgery, as well as penalties and fees under Sec. 19(k), 19(l) and Sec. 16 for Respondent's failure to authorize the surgery recommended by Dr. Mahoney. Respondent requested to have Petitioner examined pursuant to §12 by Dr. Bednar at Loyola Medical Center for an opinion on reasonableness, necessity and causal connection. No record was made. Commissioner White issued an order dated March 15, 2012. Commissioner White found that Respondent's was entitled to the §12 examination and ordered Respondent to pay to Petitioner the reasonable and necessary travel costs incurred after he arrives in Illinois from Arizona. (Order, 3/15/12)

8. Petitioner also offered the §12 examination report dated May 29, 2012 by Dr. Michael Bednar of Loyola University Medical Center's Department of Orthopaedic Surgery and Rehabilitation. The report states Dr. Bednar's opinion that Petitioner's current condition of left

wrist arthritis is causally connected to the August 8, 2008 work accident. Dr. Bednar agreed with the treatment recommendations of Dr. Mahoney. (PX 7) Respondent authorized the left wrist fusion. At the §19(h) and §8(a) hearing on July 25, 2013, Petitioner testified that he did not receive reimbursement for his travel costs. (T. 23-25)

9. Petitioner returned to Dr. Mahoney on August 7, 2012. Petitioner continued to have pain with flexion and extension and wanted to proceed with the fusion. Petitioner's pre-operative x-ray showed severe osteoarthritic changes involving both the proximal and distal carpal joints as well as the distal radiolunar joint. (PX 5)

10. On October 17, 2012, Dr. Mahoney performed a left wrist arthrodesis with matched resection of the distal ulnar head and removal of prior hardware. The surgery took place at the St. Michael's Surgery Center in Scottsdale, Arizona. (PX 8)

11. Petitioner declined to undergo formal post-operative physical therapy and performed exercises at home and utilized a bone growth stimulator prescribed by Dr. Mahoney. On December 13, 2012, Dr. Mahoney noted that Petitioner complained of some slight soreness and stiffness but had made exceptional gains performing his own physical therapy exercises. On exam, he was found to have a slightly decreased ability to pronate and supinate his left wrist as compared to his right wrist. His bilateral wrist strength was tested with a Jamar dynamometer at 40 kilograms on the left and 95 kilograms on the right. Dr. Mahoney recommended that Petitioner continue using the bone growth stimulator and performing exercises for active pronation and supination and to increase his grip strength. (PX 5)

12. On January 17, 2013, Petitioner was not having much pain and was now able to touch the tip of his thumb to the base of his small finger. Dr. Mahoney released Petitioner to right-hand duty on January 25, 2013. (PX 5)

13. On February 19, 2013 Petitioner complained that he was having pain with pronation and supination of his left wrist. On exam, Dr. Mahoney found 45 degrees of supination past neutral on the left and full pronation on the left. His grip strength test results were 55 kilograms on the left and 85 kilograms on the right. Dr. Mahoney stated that he would continue to follow Petitioner until his range of motion and strength numbers reached a plateau indicating maximum medical improvement. (PX 5)

14. On April 2, 2013, Petitioner reported to Dr. Mahoney that he had intermittent pain and that he was no longer actively trying to rotate his wrist due to pain. On exam, Petitioner's left wrist pronation was again full and symmetrical with the right and he was again at 45 degrees of supination past neutral. His left wrist strength was 45 kilograms on the left and 95 kilograms on the right. Dr. Mahoney noted that Petitioner was happy with his level of function and did not wish to undergo additional therapy. Dr. Mahoney released Petitioner from care. A Work Status Report was issued by Dr. Mahoney on April 16, 2013. The form indicates that Petitioner was restricted from lifting over ten pounds with his left hand. (PX 5)

15. At the 19(h) and 8(a) hearing on July 25, 2013, Petitioner testified that he notices he is unable to rotate his wrist and that he has difficulty buttoning his pants and is unable to use a

drive-up ATM machine with his left hand. He testified that at the time of the August 2, 2010 arbitration, these activities were not a problem for him. (T. 22-23) Petitioner voluntarily resigned his employment effective October 26, 2009 and moved to Arizona. (T. 31-32) He currently has no treatment recommendations pending for his left hand and takes no prescription medications. (T. 33-34)

ANALYSIS

After consideration of the facts in this case, the Commission finds that Petitioner proved a material increase in his work-related physical disability since the arbitration hearing on August 2, 2010. His left hand disability is causally related to his original work-related accident on August 8, 2008. Petitioner is entitled to temporary total disability benefits from the date of surgery, October 17, 2012, through January 25, 2013. As previously ordered by the Commission, Petitioner is entitled to any unpaid reasonable and necessary travel costs incurred in Illinois as related to Respondent's §12 examination by Dr. Bednar. The Commission finds that Petitioner sustained additional permanent disability to his left hand with respect to his range of motion and grip strength, but we do not find that Petitioner has sustained a loss of occupation and we do not find an award under §8(d)2 for the person-as-a-whole to be appropriate. Petitioner voluntarily resigned from his job in October of 2009 and moved to Arizona. No physician has opined that Petitioner cannot pursue his former occupation and Petitioner has not attempted to find work as an operating engineer. Therefore, the Commission finds that Petitioner has incurred a further loss of 17.5% of the left hand since the prior arbitration award.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petitioner under Sections 19(h) and 8(a) is hereby granted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $819.22 per week from December 3, 2010 through December 9, 2010 and from October 17, 2012 through January 25, 2013, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $664.72 per week for a further period of 35.875 weeks, as provided in §8(a) of the Act, for the reason that the Petitioner's has sustained a material increase of his work related disability representing 17.5% of the left hand.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner $165.00 for travel expenses related to Respondent's §12 examination by Dr. Bednar at Loyola University Medical Center on May 29, 2012, minus any amounts paid by Respondent to date.

14IWCC0382

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $26,100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 27 2014
RWW/plv
o-2/19/14
46

Ruth W. White

Michael J. Brennan

David L. Gore

STATE OF ILLINOIS)
) SS.
COUNTY OF DEKALB)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

David Syverson,
Petitioner,

vs.

NO: 10WC 31874

The Weitz Company,
Respondent,

14IWCC0383

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causation, notice, temporary total disability, medical, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 23, 2013, is hereby affirmed and adopted.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 27 2014
o052114
CJD/jrc
049

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) DECISION OF ARBITRATOR

SYVERSON, DAVID
Employee/Petitioner

Case# **10WC031874**

14IWCC0383

THE WEITZ COMPANY
Employer/Respondent

On 4/23/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0190 LAW OFFICES OF PETER F FERRACUTI PC
JENNIFER L KIESEWETTER
110 E MAIN ST PO BOX 859
OTTAWA, IL 61350

1120 BRADY CONNOLLY & MASUDA PC
PAUL PASCHE
ONE N LASALLE ST SUITE 1000
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF DEKALB)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

DAVID SYVERSON
Employee/Petitioner

v.

THE WEITZ COMPANY
Employer/Respondent

Case # 10 WC 31874

Consolidated cases: None

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **George Andros**, Arbitrator of the Commission, in the cities of **New Lenox and Geneva**, on **January 10, 2013, and March 11, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the alleged date of accident, **7/23/2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$4,692.76**; the average weekly wage was **$1,173.19**.

On the alleged date of accident, Petitioner was **33** years of age, ***married*** with **2** dependent children.

Respondent ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent has paid no benefits to Petitioner.

ORDER

The arbitrator finds that no compensable accident occurred, therefore no benefits are awarded. The petitioner's Application for Adjustment of Claim and subsequent petitions for benefits and penalties are hereby denied. This matter is dismissed.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

/s/ George Andros
Signature of Arbitrator

Apr 19, 2013
Date

ICArbDec19(b)

APR 23 2013

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DAVID SYVERSON,	)	
	)	
Petitioner,	)	
	)	
v.	)	No.: 10 WC 31874
	)	
WEITZ INDUSTRIAL,	)	
	)	
Respondent.	)	

ATTACHMENT TO ARBITRATION DECISION

STATEMENT OF FACTS

The arbitrator finds that Petitioner failed to prove that he sustained accidental injuries that arose out of and in the course of his employment by Respondent on July 23, 2010, or at any time while he worked for Respondent. The petitioner only worked a short period of time for the respondent and the medical records prior to this employment contained evidence of carpal tunnel syndrome. Specifically, the petitioner received treatment for right carpal tunnel syndrome in June through August 2008, and for bilateral wrist pain during March, April and early June 2010. He began working for Respondent on June 23, 2010. In addition, the petitioner's own testimony established that his job duties for Respondent involved a variety of tasks, none of which were individually performed throughout the day. None of the duties specifically involved force combined with static posturing or with repetitive grasping. This evidence supported Dr. Carroll's opinion that Petitioner's employment by Respondent was not a cause of his bilateral carpal tunnel syndrome or his bilateral lateral epicondylitis.

Petitioner testified that in 2008, he sustained a work-related injury to his right hand, for which he obtained a settlement. He received treatment from Dr. Speca until October 2008. According to the records of Dr. Speca (RX2 and PX5), Dr. Garg performed an EMG/NCV on July 31, 2008, that demonstrated carpal tunnel syndrome of the right arm. Dr. Speca noted paresthesias and wrist pain (RX3), but Petitioner denied feeling any numbness at that time. On August 25, 2008, Dr. Speca recommended surgery to release the right carpal tunnel. (RX3, PX5). Dr. Speca also noted that Petitioner had a torn cartilage that might be putting pressure on the median nerve, and he recommended surgical excision. (RX3, PX5).

Petitioner testified that he worked on eleven different jobs between October 2008 and May 2010, and he prepared a written summary of each job. (RX 1, Dep. Ex.3). According to his job summary, Petitioner worked for following

employers in Iowa: 1) Day & Zimmerman in the Quad Cities from March 8, 2010, to April 9, 2010; at Newell in Cedar Rapids from April 26, 2010, to May 1, 2010, and then for Hayes Mechanical in Muscatine from May 13, 2010, to May 15, 2010. (RX1, Dep. Ex. 3). According to the records of Petitioner's union, he worked 132 hours for Day & Zimmerman, 69.25 hours for Newell, and 43 hours for Hayes Mechanical. (RX1, Dep. Ex. 4).

On March 18, 2010, Petitioner complained of bilateral wrist pain to Dr. Beck, and noted that he had been "working in Iowa." (PX 2). Dr. Beck prescribed a Medrol Dosepak. (PX2). Petitioner called back on March 30, 2010, stating that he "would like something for the pain from carpal tunnel. In Iowa working." (PX2). Dr. Beck prescribed another Medrol Dosepak and Anaprox. (RX2). On April 27, 2010, Petitioner called back and stated he "would like something stronger than Vicoprofen, in Iowa using hands a lot." (RX2). Petitioner was prescribed Norco. (RX2). On June 4, 2010, Dr. Beck switched Petitioner from Norco to Tramadol. (RX2). On June 10, 2010, she changed Petitioner's prescription from Tramadol to Tylenol No. 3; and on June 14, 2010, she was changed it from Tylenol No. 3 to Mobic. (RX2).

At trial, Petitioner testified on direct examination that he had "no problems" with his hands or arms prior to working for Respondent. Later, he conceded that he had nagging pain in one wrist. On cross-examination, he admitted the nagging pain was in both wrists. The arbitrator finds Petitioner's credibility questionable in light of his own contradictory admissions, as well as the undisputed medical records of treatment prior to June 23, 2010.

According to his written work history, when Petitioner worked for Respondent, he performed rigging and welding, installing structures and welding one to four hours per day. (RX1, Dep. Ex. No. 3). At trial, he testified that the installations included moving heavy beams, beating them into place with hammers, using chain falls and comealongs to move beams, welding, and using other tools. On cross-examination, he stated that some days he spent the entire shift moving objects, and some days he only did minimal welding. Petitioner worked for Respondent from June 23, 2010, until July 23, 2010, a total of 184.5 hours. (RX1, Dep. Ex. 3, 4; RX4).

On August 9, 2010, Dr. Beck referred Petitioner to Dr. Perona. (PX2). Petitioner filed his Application for Adjustment of Claim on August 19, 2010. (Arb. Ex. No. 2). On December 30, 2010, Petitioner requested Dr. Beck to refer him to Dr. Urbanosky, and his first visit with Dr. Urbanosky was on January 14, 2011. PX2, PX6. Dr. Urbanosky initially diagnosed only bilateral lateral epicondylitis and medial epicondylitis. (PX6). She prescribed physical therapy. (PX6).

Petitioner continued working full time without any medical restrictions during the rest of 2010. (RX1, Dep. Ex. No. 4; PX2.)

In 2011, Petitioner worked every month except January and July, amassing 1,261.75 hours on ten job sites with four different employers. (RX1, Dep. Ex. 4). This was his highest annual total hours since he joined the millwrights union in 2005, by more than 400 hours. (RX1, Dep. Ex. No. 4).

On February 18, 2011, Petitioner underwent an EMG/NCV that revealed bilateral carpal tunnel syndrome. PX6. Dr. Urbanosky injected Petitioner's right carpal tunnel on February 25, 2011, and his left carpal tunnel on April 25, 2011. (PX6). On June 28, 2011, Dr. Urbanosky performed a right carpal tunnel release surgery, and on August 30, 2011, she performed a left carpal tunnel release surgery. (PX6). In the interim, on July 15, 2011, Dr. Urbanosky had recommended plasma-rich protein (PRP) injections to treat the bilateral lateral epicondylitis. (PX6).

Although Dr. Urbanosky restricted Petitioner from working from June 28, 2011, until October 14, 2011(PX6)(and Petitioner is claiming temporary total disability for that period (Arb. Ex. No. 1)), Petitioner's union records show that he worked 185 hours during August 2011, and he worked 191 hours during September 2011. (RX1, Dep. Ex. No. 4). The arbitrator questions petitioner's credibility in light of his non-compliance with his physician's restrictions.

Dr. Charles Carroll IV examined Petitioner at Respondent's request on November 16, 2011. (RX1, p. 7). Dr. Carroll is a board-certified orthopaedic surgeon with a sub-specialty certification in hand surgery, a professor at Northwestern University Medical School, and frequent lecturer and author on diagnosis and treatment of conditions of the hand. (RX1, Dep. Ex. No. 1). He devotes about 20% of his practice to treatment of either carpal tunnel syndrome or medial or lateral epicondylitis. (RX1, pp. 6-7.) He reviewed the records from Dr. Beck, Dr. Speca and Dr. Bednar, as well as the written work history prepared by the petitioner and the certified records from Petitioner's union. (RX1, pp. 7-9).

Dr. Carroll noted that Petitioner reported he was working 10 hours per day, six days per week for Respondent in June 2010. (RX1, p. 13; Dep. Ex. No. 2). Petitioner testified at trial that he answered Dr. Carroll's questions truthfully. However, the wage records show Petitioner worked an average of 42.9 weeks between June 23, 2010, and July 23, 2010. (RX4). The arbitrator questions the petitioner's credibility with regard to his testimony about the amount of work he performed for Respondent.

On examination, Dr. Carroll noted the petitioner was obese (weighing 315 pounds with a height of six feet, two inches.) (RX1, Dep. Ex. No. 2). Petitioner confirmed his height and weight at trial. Dr. Carroll noted no symptoms of carpal tunnel syndrome, but evidence of bilateral lateral epicondylar pain with slight radial nerve pain and lack of sensation in the ulnar nerve distribution on the right. (RX1, Dep. Ex. No. 2). Dr. Carroll found no physical findings consistent with bilateral medial epicondylitis. (RX1, p. 17.) Dr. Carroll explained that lateral

epicondylitis is a disease process that causes pain in the elbow radiating to the wrist, and it is typically manifested when cocking the wrist away from the palm. (RX1, pp. 17-18.) Medial epicondylitis, or "golfer's elbow," is on the inner side of the elbow (toward the "baby finger") and typically causes pain with grasping and with flexion of the wrist, such as with hitting a golf ball. (RX1, p. 18). Petitioner's examination showed full grip strength. (RX1, Dep. Ex. No. 2.)

Based on his examination findings and review of Petitioner's work history, Dr. Carroll opined that Petitioner's bilateral carpal tunnel syndrome and epicondylitis was a degenerative condition, and he did not find any evidence of an industrial injury. (RX1, Dep. Ex. No. 6). At his deposition, he testified to a reasonable degree of medical and surgical certainty that he was not able to attribute the development of the epicondylitis or carpal tunnel problems to one employer or to Petitioner's work activities in July 2010. (RX1, p. 24.) Dr. Carroll stated that although Petitioner's work was hard, due to the number of hours worked, and due to the fact that the disease is degenerative in nature, he could not attribute it to one particular employer. (RX1, p. 24.)

Dr. Carroll was then presented with a hypothetical question that included the same work history provided by the petitioner (RX1, Dep. Ex. No. 3), the same medical history as contained in the records of Dr. Beck (PX2) and Dr. Speca (RX2; PX5), and Dr. Urbanosky (PX6). Based on these facts, Dr. Carroll opined that Petitioner's carpal tunnel syndrome developed prior to his employment by Respondent and did not believe it came from the occupational activities performed while working for Respondent. (RX1, pp. 25-28). Dr. Carroll opined that Petitioner's bilateral lateral epicondylitis would not be attributed to any one employer in the hypothetical. (RX1, p. 28.) If the hypothetical was changed to add precision welding duties while working for Respondent, Dr. Carroll's opinions still would not change. (RX1, p. 29.) If the petitioner worked up to 53.5 hours per week, Dr. Carroll would not change his opinion, as he believed Petitioner's epicondylitis developed over time. (RX1, p. 29). Given the petitioner's prior treatment, and the development and time of development of symptoms, Dr. Carroll felt that the petitioner's problems occurred or manifested prior to his employment with Respondent. RX1, p. 33).

In her testimony, Dr. Urbanosky agreed that in order to render an accurate causation opinion, a complete and accurate history was required. (PX8, p. 27). In particular, Dr. Urbanosky conceded that the petitioner's prior physician, Dr. Speca, had recommended carpal tunnel surgery as early as August 25, 2008. (PX8, p. 32). Dr. Urbanosky admitted she never reviewed any records regarding Petitioner's medical treatment by Dr. Beck in 2010. (PX8, pp. 38-39.) She was also unaware of how many different employers Petitioner worked for in 2008, 2009 or 2010. (PX8, p. 39). In fact she had no knowledge of any other jobs or symptoms. (PX8, p. 40). Depending on what Petitioner was doing at any other employers during that period, Dr. Urbanosky stated it could contribute to his symptoms for which she saw him. (PX8, pp. 39, 41). Dr. Urbanosky had no

knowledge of how much time the petitioner had spent working for Respondent in comparison with the amount of time he worked for other companies. (PX8, p. 40). Dr. Urbanosky testified that it was her understanding that he performed the same type of work while working full duty for Respondent in July 2010, and this continued until the date of her first surgery on June 28, 2011. (PX8, p. 46). Dr. Urbanosky agreed that Petitioner was initially determined to have only mild, or minimal, left carpal tunnel syndrome at the time of the EMG on February 18, 2011. (PX8, p. 48). On August 15, 2011, she noted the left hand symptoms had increased due to gripping activities. (PX8, p. 49.) This was the first time she recommended surgery for the left wrist. (PX8, p. 50). Dr. Urbanosky wrote on August 22, 2011, that Petitioner had sustained "an acute exacerbation" of pain symptoms at work at that time. (PX8, p. 50). She also agreed that his diagnostic signs worsened at that time. (PX8, p. 51). Dr. Urbanosky agreed that Petitioner's obesity was a risk factor for carpal tunnel syndrome. (PX8, p. 52). Lastly, Dr. Urbanosky conceded that her causation opinion was limited to the specific history given to her by the petitioner, and she eventually admitted that if she was presented with a different history or specific facts, she would potentially render a different opinion. (PX8, p. 59-60).

Because Dr. Urbanosky did not have Petitioner's complete medical history and work history, and because the history she relied on was not consistent with the work records and medical records in evidence, the arbitrator finds Dr. Carroll's opinions to be more credible and persuasive on the issue of causation.

Furthermore, the arbitrator notes that Dr. Urbanosky testified that the treatment she had recommended for treatment of Petitioner's elbows, protein rich plasma injections, is still considered to be an experimental procedure. (PX8, p. 51). Dr. Carroll agreed that "there's some question as to the science, ...and further research is being done to see if it's truly effective." (RX1, p. 21).

CONCLUSIONS OF LAW

With regard to the issue of (C), whether an accident occurred that arose out of and in the course of Petitioner's employment by Respondent, the arbitrator concludes:

The petitioner failed to meet his burden of proving by a preponderance of the credible evidence that his bilateral hand or arm injuries arose out of and in the course of his employment with the respondent. The petitioner failed to prove either a single incident causing a definable objective injury or an injury due to repetitive work activities. The crux of the matter is that although repetitive injuries can be compensable, the petitioner must prove that the injury is actually work-related, and not the result of normal, degenerative aging processes. *Peoria County Belwood Nursing Home v. Industrial Commission*, 115 Ill.2d 524, (1987). Even if the petitioner is seeking benefits for repetitive trauma, he must meet the same standard of proof as a petitioner alleging a single, definable accident.

Three "D" Discount Store v. Industrial Commission, 198 Ill.App.3d 43 (1990). Here, the petitioner failed to provide evidence of any objective medical condition or that any such condition was related to his employment activities while working for the respondent.

Petitioner's direct testimony was contradicted by his own later testimony, as well as the job description he prepared himself, with regard to his job duties, his dates of employment, his prior medical treatment, and his compliance with the recommendations of his treating physicians. Therefore, the arbitrator concludes that the documentary evidence is more reliable than Petitioner's testimony. Petitioner only worked for Respondent for a little over four weeks during June and July 2010. Prior to that, from June 2008 through May 2010, he worked for 14 other employers, and had reported pain and numbness symptoms in his hands and sought medical attention. In March 2010, and up through the week before he started working for Respondent, Petitioner had numerous encounters with Dr. Beck and received treatment for bilateral arm and wrist pain. Dr. Beck's records specifically mention Petitioner's work in Iowa during this period, and the records show Petitioner worked for three different employers in Iowa during those months. Petitioner's right carpal tunnel syndrome was clearly diagnosed by EMG on July 31, 2008. His left carpal tunnel syndrome was clearly "minimal" until August 2011, over a year after he last worked for Respondent. Even without expert testimony, the arbitrator concludes based on the evidence that Petitioner's bilateral carpal tunnel syndrome did not arise out of his employment, because it manifested itself at times when the petitioner was not employed by the respondent.

However, the expert testimony also leads to the same conclusion for both the bilateral carpal tunnel syndrome and the bilateral epicondylitis. Two experts testified—Dr. Carroll and Dr. Urbanosky. Only Dr. Carroll had reviewed the petitioner's correct work history and documentation of hours and duties. Only Dr. Carroll reviewed Petitioner's medical records with regard to his treatment for bilateral arm pain between March 2010 and June 2010. Dr. Urbanosky conceded that her causation opinion was dependent on an accurate history, but she did not have an accurate history. Therefore, the arbitrator concludes that Dr. Carroll's opinions carry more weight. Dr. Carroll concluded that Petitioner's bilateral carpal tunnel syndrome clearly occurred outside his dates of employment with Respondent. He also concluded that Petitioner's bilateral epicondylitis was degenerative in nature and developed over the course of time prior to Petitioner's employment by Respondent. As such, Petitioner has failed to prove a nexus between his employment or job duties while working for Respondent and his medical conditions in his bilateral arms.

Furthermore, the petitioner has failed to meet his burden of proving that his injuries occurred on a date while he was employed by the respondent. Part of that burden is that the petitioner in a repetitive-trauma claim must point to a date when the injury "manifested itself," that is, the date when a reasonable person

would have been aware of the fact of her injury and the causal connection between the injury and the employment. *Castaneda v. Industrial Comm'n*, 231 Ill.App.3d 734 (1992). In *Castaneda*, the claimant first sought medical attention for carpal tunnel syndrome in April 1985, and the physician's notes reflected that the claimant related her symptoms to her work. She continued to work until 1988, when her hands were hurting excessively and she returned for medical attention. She was restricted from work at that point, and ultimately underwent carpal tunnel surgery to both hands in 1989. She filed her application for benefits in September 1988. The Commission determined that her injury had manifested itself in 1985, when the petitioner first sought treatment and related the condition herself to her work duties. The court affirmed this decision, noting that in some cases the manifestation date may be the last day worked, but not in the case of a petitioner who had already shown that she was reasonably aware of both the fact of her injury and its relation to her work. *Castaneda*, 231 Ill.App.3d at 738-739.

In this case, the petitioner was clearly aware of the fact of his injury no later than March 18, 2010, when he complained of bilateral wrists pain to Dr. Beck and attributed it to "working in Iowa." PX2. Again, less than two weeks later, on March 30, 2010, he specified he had "the pain from carpal tunnel" while he was "in Iowa working." PX2. On April 27, 2010, he again related his symptoms to his work, telling Dr. Beck that he was "in Iowa using hands a lot." PX2. It is clear, therefore, that the petitioner was not only aware of the condition of his hands, but was also attributing it to his work for a different employer in Iowa over three months before he began working for the respondent. Under the holding in *Castaneda*, the petitioner's manifestation date was prior to his employment with the respondent, and thus he failed to prove the work for the respondent was responsible for the conditions in his upper extremities.

The only expert testimony offered by the petitioner was the opinion of Dr. Holtkamp. However, Dr. Holtkamp admitted she did not have any knowledge of the date of onset of the petitioner's symptoms or his job duties for the respondent, other than "precision welding." PX8, pp. 26,___. Dr. Urbanosky did not review any of the prior treatment records, including those of Dr. Beck, and Dr. Urbanosky had no knowledge of the petitioner's other jobs, including his job in Iowa in March and April 2010. PX8, pp. 38-39. Dr. Urbanosky admitted that if the petitioner had complaints of pain "after doing (another) job that he could refer to a job and then sought treatment, I would definitely thing that those activities contributed to his symptoms for which I saw him." PX8, pp. 40-41. In fact, the petitioner did complain of pain severe enough to warrant several medications, including Medrol, vicoprofen, and Mobic. He directly referred his complaints to his work in Iowa in March and April 2010. Dr. Holtkamp's testimony therefore supports the conclusion that the petitioner's conditions were not related to his work for the respondent, but to his activities elsewhere.

Dr. Carroll's testimony further supports this conclusion, and Dr. Carroll was the only physician with the benefit of having reviewed all of the records, including those of Dr. Speca and Dr. Beck. Dr. Carroll testified: "Given the

development and the time of development, it would indicate it occurred or manifested itself prior to his employment (by the respondent)." RX 1, p. 33.

The arbitrator therefore concludes that the petitioner failed to prove that he sustained accidental injuries that arose out of and in the course of his employment by the respondent. The arbitrator further concludes that the petitioner's condition of ill-being in his bilateral upper extremities manifested themselves prior to his employment by the respondent. As such, the petitioner has failed to prove his entitlement to any benefit under the Act, and his application for benefits is therefore denied and no benefits are awarded.

With regard to the issue of (F), whether the petitioner's current condition of ill-being is causally related to the alleged injury, the arbitrator concludes:

Given the arbitrator's decision with regard to the issue of accident, the arbitrator further finds the petitioner failed to prove that his current condition of ill-being is related to any compensable work injury attributable to the respondent.

With regard to the issues of (J), whether the medical services that were provided to Petitioner were reasonable and necessary, (K), whether Petitioner is entitled to any prospective medical care, and (L), whether Petitioner is entitled to any temporary total disability benefits, the arbitrator concludes:

Given the arbitrator's decision with regard to the issue of accident, the remaining issues are moot. The arbitrator further concludes the petitioner was not entitled to any medical treatment or disability benefits related to any compensable work injury. Petitioner's request for any workers' compensation benefits is therefore denied.

With regard to the issue of (M), whether penalties or fees should be imposed upon Respondent, the arbitrator concludes:

Given the evidence offered by Respondent, and the arbitrator's decision with regard to the issue of accident, the arbitrator concludes that Respondent had just cause for denying liability for benefits. The arbitrator therefore denies Petitioner's requests for penalties or attorney's fees.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Joshua W. Hoback,
Petitioner,

vs.

NO: 11WC 24324

14IWCC0384

Tri-County Coal,
Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical, temporary total disability, permanent partial disability, nature and extent and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 1, 2013, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $66,200.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 27 2014
o042214
CJD/jrc
049

Charles J. DeVriendt

Daniel R. Donohoo

DISSENT

I respectfully dissent from the majority. Petitioner failed to prove that his present condition of ill-being is causally connected to the accident of February 28, 2011.

I would find that Petitioner's herniated disc at L4-5 and the resulting low back surgery are not causally connected to the accident of February 28, 2011. Petitioner had a history of low back problems preceding February 28, 2011, most specifically the accident in November of 2010 while moving a lawn mower. That injury resulted in the herniated disc as shown by the December 2010 MRI. The serious nature of that November 2010 accident is evidenced by Petitioner's loss of considerable time from work and extensive treatment.

Petitioner had not returned to full duty as of the date of this accident. He had returned to work on light duty February 8, 2011, and had not been released to full duty. Dr. Pineda testified that the herniated disc at L4-5 was a result of the annular tear which occurred in November of 2010, not an annular tear as a result of this accident. He stated that further extrusions could occur with no trauma whatsoever.

Petitioner did not have left leg complaints following this accident. It was not until three weeks later that he first made those complaints. As noted by Dr. Pineda, further extrusion could have occurred at any time prior to the MRI taken nearly a month following this accident.

The opinions of Dr. DeGrange, Petitioner's treating surgeon, are to the effect that this accident did not cause the condition for which he operated.

For these reasons, I respectfully dissent.

Ruth W. White

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

OBACK, JOSHUA W
Employee/Petitioner

Case# **11WC024324**

TRI-COUNTY COAL
Employer/Respondent

14IWCC0384

On 3/1/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.13% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

2427 KANOSKI & ASSOCIATES
KATHY A OLIVERO
2730 S MacARTHUR BLVD
SPRINGFIELD, IL 62704

0332 LIVINGSTONE MUELLER ET AL
DENNIS S O'BRIEN
P O BOX 335
SPRINGFIELD, IL 62705

14IWCC0384

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Joshua W. Hoback
Employee/Petitioner

v.

Tri-County Coal
Employer/Respondent

Case # **11 WC 24324**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the *Honorable Nancy Lindsay*, Arbitrator of the Commission, in the city of Springfield, on January 9, 2013. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other

FINDINGS

On **February 28, 2011,** Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$49,975.12;** the average weekly wage was **$961.06.**

On the date of accident, Petitioner was **31** years of age, ***married*** with **2** dependent children.

Petitioner ***has received*** all reasonable and necessary medical services.

Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$0.00** in TTD, **$0.00** in TPD, **$0.00** in maintenance, **$6,628.58** in non-occupational indemnity disability benefits, and **$0.00** for other benefits, for a total credit of **$6,628.58**.

Respondent is entitled to a credit under Section 8(j) of the Act for medical bills paid through its group medical plan.

ORDER

• Respondent shall pay Petitioner temporary total disability benefits of **$640.74**/week for 18 6/7 weeks, from March 1, 2011 through July 10, 2011, as provided in Section 8(b) of the Act.

• Respondent shall pay Petitioner the sum of **$576.64**/week for a further period of 100 weeks as provided in Section 8(d)(2) of the Act, because the injuries sustained caused 20% loss of use of the person as a whole.

• Respondent shall pay Petitioner compensation that has accrued from February 28, 2011 through January 9, 2013, and shall pay the remainder of the award, if any, in weekly payments.

• Respondent shall pay the further sum of **$3,216.41** for necessary medical services, pursuant to the medical fee schedule, as provided in Sections 8(a) and 8.2 of the Act, and shall be given a credit for payments made by the group medical plan, and shall hold Petitioner harmless from any claims by any provider of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

RULES REGARDING APPEALS UNLESS a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment;

however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

February 26, 2013
Date

MAR 1 - 2013

The Arbitrator finds:

Petitioner has been employed by Respondent since 2004 as a roof bolter. As a roof bolter, Petitioner drills holes into the ceilings of mines and puts six and eight foot pieces of rebar into the holes with glue. To perform his duties as a roof bolter, Petitioner is on his feet all day and engages in a lot of lifting, carrying, and twisting. Petitioner estimated that the weights of the items he lifted and handled ranged from 10-40 pounds.

Petitioner testified that prior to February 28, 2011, he had occasional complaints involving his lumbar spine but nothing like what he experienced on that day. Petitioner was born with scoliosis and has experienced some occasional mild soreness from his shoulders to his low back since he was about 20 years of age. Petitioner had treated with Dr. Wade of Carlinville Chiropractic Clinic for complaints he had in his lumbar spine in June of 2010, which Petitioner described as occasional soreness and a little bit of stiffness.

The records of Carlinville Chiropractic Clinic indicate that Petitioner was seen on June 16, 2010, with complaints of lower back pain after being hit on the shoulder with a rock in the coal mine and it was noted that a back brace was given (PX 1, p. 2). These records also indicate that by June 21, 2010, Petitioner was feeling better (PX 1, p. 3). These records further show that Petitioner continued to be seen for complaints of low back pain, including soreness and achiness (PX 1, p. 3-4). However, by August 31, 2010, it was reported that Petitioner's pain was 8/10, his low back pain had gotten worse at work, and Petitioner had been taken off work (PX 1, p. 4). Thereafter, the records show that Petitioner's low back pain was better but Petitioner was still sore (PX 1, p. 5-7). The diagnosis noted for Petitioner's condition of ill-being was low gluteal spasm (PX 1, p. 1-7). On cross-examination Petitioner acknowledged that his family physician, Dr. Schleeper, took him off work in August and September of 2010 for his low back pain.

On November 7, 2010, Petitioner sustained an injury to his low back when he tried to drag a lawn mower out of his garage. Petitioner initially noticed lower back pain but then the pain started to move down his right leg. Petitioner was seen on November 8, 2010, at Carlinville Chiropractic Clinic and reported that the day before he was pulling a lawn mower out of his garage and felt pain in his right lower back when he walked (PX 1, p. 8). It was noted that Petitioner was off work and that Petitioner continued to be off work as of November 24, 2010 (PX 1, p. 9). These records also show that Petitioner continued to complain of low back pain with soreness to the right calf, and on November 29, 2010, Dr. Wade referred Petitioner to Dr. Western (PX 1, p. 9-10). Petitioner did not think he used a cane after the accident with the lawn mower, but the records of Carlinville Chiropractic Clinic reported that he was doing so on November 8, 2010 and again on January 3, 2011 (PX 1, p. 8, 12).

Petitioner was initially seen by Dr. Western on December 13, 2010 for evaluation of back and leg pain which, by history, began in early November of 2010 when Petitioner was pulling a riding lawn mower out of his garage. Petitioner reported difficulty bending, walking, and lifting, the latter of which Petitioner described as "nearly impossible." Petitioner had been under the care of his chiropractor, Dr. Wade and he had been treating Petitioner's leg and back pain. Dr. Wade referred Petitioner to Dr. Western. Petitioner had difficulty getting up and standing and had an antalgic gait with a slightly forward flexed posture. Extending his back seemed to help a bit but forward flexing was definitely worse. Straight

leg raising caused pain in the back of both legs. There were no significant neurological deficits detected with both strength and sensation present in the lower extremities. Some tenderness across Petitioner's low back and SI joints was noted. X-rays were taken which showed very slight scoliosis (PX 3). An MRI was ordered. Dr. Western suspected a disc herniation with some nerve root irritation. Light duty restrictions were given. (PX 2)

A lumbar spine MRI was performed on December 28, 2010 due to low back pain radiating down Petitioner's right leg after a lifting injury two months earlier. It revealed a large right subarticular disc extrusion at L4/5 causing severe right lateral recess stenosis and effacement of the descending right L5 nerve root. (PX 3)

Petitioner continued receiving chiropractic treatment for his low back during this time. He did miss some work, limped on occasion, and used a cane. Petitioner was given two right L5/S1 transforaminal injections in January of 2011. (PX 1) Petitioner testified that his pain and discomfort improved with the injections and he was moving pretty well. (PX 1)

Dr. Western followed-up with Petitioner on February 16, 2011. In the interim, Petitioner had undergone two epidural injections and was doing very well (1/10 pain level). Occasionally, he reported a "little bit in his leg," but he described it as more of an ache and nothing of great significance. Petitioner's diagnosis was disc herniation with right lower leg radiculopathy. Petitioner was told to start a home exercise program and they anticipated getting Petitioner back to regular duty as a roof bolter within a couple of weeks. (PX 2) Petitioner testified that he believed he was to be released to full duty work as of March 1, 2011.

Petitioner was seen at Carlinville Physical Therapy on February 21, 2011, regarding his bulging disc and low back pain. Petitioner reported leg pain descending down to his right calf. Petitioner was noted to be grimacing and slow to change positions. Medications included Vicodin and Flexeril. Petitioner was reportedly working light duty.

Petitioner returned to his chiropractor on February 23, 2011. The notes are difficult to read but Dr. Wade noted an "exacerbation." (PX 1)

Petitioner was involved in an undisputed accident at work on February 28, 2011. He was dusting returns with a co-worker named "Brian." According to Petitioner, Brian was dragging a hose in a crosscut fashion when Petitioner tripped over the hose, turned, and landed on the ground on his hands and knees. Petitioner testified that while he was on the ground, his lower back felt sore and he was unable to get up because it was pretty painful. A passing mine examiner assisted him from the ground. When Petitioner stood up, he noticed he could not stand up straight as he was experiencing a pretty intense pain in his low back. Petitioner was taken out of the mine and transported to St. John's Hospital in Springfield by ambulance.

The records of St. John's Hospital show that Petitioner was seen at approximately noon with complaints of back pain after tripping on a hose in a coal mine and that Petitioner had fallen forward injuring his lower back, that Petitioner has a history of bulging discs, and that he rated his pain as 3/10 (PX 4, p. 2). It was noted that there was evidence of pain or distress and that Petitioner also complained of weakness (PX 4, p. 2, 3). Additional records of St. John's Hospital reported that Petitioner was a 36 year old female that was limping with complaints of right foot pain since a fall at school and that the onset was 5-6 days earlier (PX 4, p. 7). X-rays of Petitioner's lumbar spine showed no compression fracture of

subluxation but loss of the normal lumbar lordosis that may be related to patient positioning versus muscle spasm (PX 4, p. 9). The records also reported that Petitioner was given an injection in the left and right upper outer gluteal areas, that Petitioner's pain intensity was 7/10, that Petitioner was prescribed medications of Ibuprofen and Hydrocodone, and that Petitioner was referred to Springfield Clinic MOHA (PX 4, p. 4, 5). Petitioner thought that he reported to the medical personnel at St. John's Hospital that the pain he was experiencing in his low back was 9/10 and he had pretty sharp pain in his right foot that would also go numb. Petitioner denied telling anyone at the hospital that he fell at school. After his release from St. John's Hospital, Petitioner was taken by his wife to Dr. Western at Springfield Clinic.

Petitioner testified that he had to be taken by wheelchair to be seen by Dr. Western as he was unable to stand up or walk.

According to Dr. Western's notes, Petitioner was doing well on light duty at work and was scheduled to go back to regular duty on "Wednesday;" however, earlier in the day (the 28th) he was at work, tripped over a hose, fell and had re-injured his back. Petitioner was complaining of severe back pain and had to be taken out of the mine. Petitioner had been seen at St. John's Hospital earlier and undergone x-rays and given a couple of pain injections which didn't help much. Petitioner described his pain as being in the axial low back and not radiating down to his legs. Petitioner did report that he had significant enough pain that it felt uncomfortable to bear full weight on his right leg as he didn't think it would hold him up. Petitioner was able to get up and bear weight on his leg but couldn't ambulate or put much weight on his leg. Straight leg raising was negative although it caused some pulling and pain in his lower back. Dr. Western's diagnosis was a lumbar strain. Dr. Western also noted, "Thankfully, he is not having any radicular symptoms at this time." (PX 2, p. 40) Petitioner was given a week off of work. (PX 2)

Petitioner was also examined at MOHA on February 28, 2011. Petitioner's history of back problems was noted, including a back injury occurring three months earlier at home. Petitioner reported no disc herniations as a result of that injury but some right lower extremity radiculopathy. Petitioner had been treated with two disc injections and he had been making good progress with his injury. Petitioner was working light duty as a result of that accident (limited bending and no lifting over twenty lbs.) Petitioner was getting ready to return to full duty on March 2, 2011. Petitioner related a sudden recurrence of back pain with the Feb. 28th incident. He reported quite a bit of trouble walking afterwards and was taken to St. John's emergency room where x-rays were taken and reportedly within normal limits. Petitioner was given ibuprofen and Norco and told to follow up with MOHA. Petitioner's visit with Dr. Western on the 28th was also noted. He was taken off work for one week and given prednisone and a prescription for Skelaxin. Petitioner described his pain level as "8/10" and primarily located in the mid-line lumbar region. Petitioner was experiencing some right leg symptoms, especially weakness. Petitioner felt unable to walk on his leg. The records note that Petitioner arrived in a wheelchair and was in a great amount of discomfort. He had slight lateral curvature of the spine to the left but no tenderness to the vertebral processes. Straight leg raising was negative on the left and positive on the right. Petitioner was noted to have quite a bit of difficulty getting up from his wheelchair. The doctor's physical exam was consistent with Petitioner's complaints, including Petitioner's problems standing on the leg. Dr. Bowers diagnosed Petitioner with a lumbar strain and exacerbation of his previous back injury. He was given instructions regarding medications and work. Petitioner was to return on March 2, 2011. (PX 5)

The records of Carlinville Chiropractic Clinic reported that Petitioner was seen on March 1, 2011, with complaints of pain that were noted to be 10/10 (PX 1, p. 15). On physical examination, Petitioner was found to have a positive Kemp test on the right and left, a positive patellar reflex on the right and left, a positive Eli test on the right and left, a positive leg raise on the right and left, and pain with flexion,

extension, lateral right flexion, and lateral left flexion of the dorsolumbar spine (PX 1, p. 17). The records of Carlinville Chiropractic Clinic reported that Petitioner continued to be seen there and it was noted that Petitioner was still walking with a cane as of March 4, 2011, and that it was sore to walk (PX 1, p. 15-16).

Petitioner returned to see Dr. Western on March 7, 2011. Petitioner was using a cane for walking and had not yet been back to therapy due to the most recent injury. Petitioner reported some aching pain in the right posterior leg similar to what he had experienced before. He described it as a "7/10." According to Petitioner the pain was not nearly as bad as it had been before he underwent the epidural injections which had helped him "very well." While Petitioner experienced some weakness in that leg, he denied any numbness, tingling, or sense of giving away. Dr. Western noted, "the last time I saw him, which was after he had fallen in the mine, I felt it was more of a muscular strain but, today, it is starting to appear more like his previous problem." Petitioner denied any leg pain. Dr. Western also noted, "...I advised him at this point that it does not appear work comp. will accept this as a worker's [sic] comp. injury because he did have that preexisting disc herniation, and it appears that it has been aggravated and somewhat of what it was before, so my recommendation is to go through his regular insurance because that appears to be the most appropriate way to go with this." Dr. Western observed bilateral positive straight leg raising and constant pain in Petitioner's back and right leg albeit with good mobility in the lower leg. Petitioner's strength was not significantly diminished. Petitioner was advised to remain off work unless sit down work was available. Another epidural injection and a referral to a spine surgeon were recommended. Dr. Western also completed an Attending Physician's Statement on March 7, 2011 that diagnosed Petitioner's condition as an aggravation of a disc herniation. In response to the question of whether Petitioner's condition was due to an injury or sickness arising out of Petitioner's employment, the doctor answered "yes." (PX 2)

Petitioner testified at arbitration that he was using a cane at the time of his March 7th visit with Dr. Western because he could not fully bear weight on his legs. Petitioner also testified that Dr. Western referred Petitioner to Dr. Pineda, an orthopedic surgeon, during that visit. Petitioner clarified that the complaints he had during the March 7th visit were in his right leg and not his left leg.

Petitioner underwent another epidural injection on March 10, 2011. (PX 2) Petitioner testified that this injection provided very little relief.

Petitioner was examined by Dr. Pineda on March 21, 2011. Petitioner's complaints included back pain and bilateral legal pain, the latter of which had begun in November of 2010. Petitioner's MRI showed a large L4-5 herniation, primarily off to the right. There was also a small left-sided component. Injections were reportedly helpful. Petitioner's right leg had improved and he went back to work only to have a fall with worsening back pain and left leg pain. To some degree Petitioner's right leg pain had worsened but now the real change was that he had bilateral pain with the left worse than the right. Petitioner had undergone three injections and was taking Vicodin. A new MRI was ordered. In an addendum, Dr. Pineda wrote, "Causality may be an issue here. Clearly the gentleman had pain before the work accident on the right side, but this now a more diffuse pain and it really incorporates not on the right, but more so the left, so I think we really need a new MRI to see what is going on to determine causal issues at this point." (PX 2)

Petitioner underwent a second MRI on March 25, 2011, at Carlinville Area Hospital. It was compared to the earlier MRI study of December 28, 2010 and showed an interval increase in the size of the disc protrusion as it was now broad-based and central with moderate canal stenosis and

displacement of both L5 nerve roots. Petitioner's history at that time included low back pain radiating down Petitioner's left leg. (PX 3)

After the MRI, Petitioner returned to see Dr. Pineda on March 29, 2011. Dr. Pineda read the MRI as showing the disc herniation at L4-5 but bilaterally. On physical examination, Dr. Pineda found that Petitioner was awake and alert, that Petitioner could stand, walk, and fire his hip, knee and ankle flexor and extensor. Dr. Pineda noted that he discussed the issues regarding surgical and non-surgical intervention with Petitioner, noting the treatment Petitioner had received to date, and that his only other recommendation would be a discectomy where both the right and left sides would be addressed, whether that be a laminectomy or laminotomy, but the concept of bilateral exposure was appropriate (PX 2, p. 45). Dr. Pineda noted that Petitioner was unsure if this was a work comp issue and that he was going to have to speak with his case manager, and that if not, Petitioner could use his health insurance to schedule the surgery, but Petitioner would have to make the decision (PX 2, p. 45).

At the request of Respondent, Petitioner underwent an independent medical examination with Dr. Donald deGrange on April 12, 2011. Petitioner explained that he had a history of scoliosis as a child and had experienced some back pain before the November of 2010 accident. Petitioner described both the November and February accidents for the doctor. Dr. deGrange reviewed Petitioner's medical records and the two MRIs from 2010 and 2011. He was of the opinion Petitioner sustained a herniated disc while cleaning out his garage in November of 2010. He also sustained an annular tear which was located in the same place (to the right of midline) on both MRIs. Dr. deGrange did not believe Petitioner had sustained a new injury simply because he had symptoms in the right leg and now had them in the left leg. The injury had remained the same and the symptoms have shifted from the right to the left. Dr. deGrange agreed with the need for surgery but did not believe it was due to a work-related injury. (RX 1)

Dr. deGrange prepared a report concerning his examination of Petitioner pursuant to Section 12 of the Act (RX 1). Dr. deGrange noted that Petitioner had informed him that he had experienced some back pain with a history of scoliosis he had as a child and before the incident in November of 2010, when Petitioner was clearing out his garage and trying to move an oversized lawn mower, that in picking the lawn mower up and dragging it out of the garage Petitioner had the onset of a sharp and severe low back pain. Dr. deGrange noted the treatment Petitioner had received after the incident in November of 2010, and that on February 28, 2011, Petitioner tripped over a hose he was carrying and fell landing on his outstretched hands and had the recurrence of back pain of a severe nature. Dr. deGrange noted that the November 2010 incident was the first time Petitioner had back pain with leg symptoms of any degree of severity. Dr. deGrange noted that at the time of his examination of Petitioner, Petitioner was complaining of low back pain radiating into the sacrum and buttocks on the left side, and on occasion into the calf of the left leg, that he had also experienced some numbness on the dorsum of the left leg and has occasional milder symptoms in the right foot. On physical examination, Dr. deGrange noted that Petitioner was using a cane for ambulation, that Petitioner arises from sit to stand with hesitation, there was mild to moderate tenderness at the S1 joints bilaterally and then at the lumbosacral junction with mild spasm, Petitioner stood with a slight list to the right side, straight leg raise on both sides provoked back pain at approximately 60 degrees, there were no radicular symptoms prompted by the straight-leg raising test, and there was mild decrease to light touch over the dorsum of the left foot.

Dr. deGrange reviewed the MRI studies performed on Petitioner on December 28, 2010 and March 25, 2011, and interpreted the first MRI as showing a large disc herniation at L4/5 just off to the right at midline and the annular defect is seen in the right paracentral region, and interpreted the second MRI as showing the presence of the same annular disruption at the same anatomic location, which is in the right

paracentral region, but the disc material now had spread across the midline and was occupying both sides of the spinal canal symmetrically, and causing a mild to moderate degree of stenosis bilaterally (RX 1). Dr. deGrange diagnosed Petitioner with L4/5 herniated nucleus pulposus.

Dr. deGrange opined that Petitioner sustained his initial disc herniation while he was cleaning out his garage at home in November of 2010, and then noted that Petitioner had seen Dr. Western on December 28, 2011 and March 7, 2011, who noted that Petitioner did not have any numbness, tingling or giving out of either leg, and he concluded by saying that Petitioner's symptoms appeared to be more like his previous problem. Dr. deGrange then noted that the annular defect is in the exact same spot, just to the right of the midline and that there was no new breach or rupture of the annulus but the disc material is now extravasated across the midline to occupy both sides of the spinal canal and place a mild degree of central canal stenosis on the thecal sac. Dr. deGrange concluded that given Petitioner's similar subjective complaints and the same anatomic lesion present on both MRIs that he did not sustain an injury arising out of and in the course of Petitioner's employment activities. Dr. deGrange went on to state that the fact that Petitioner was now experiencing symptoms in his left leg, whereas previously they were only in the right leg, did not imply that this was a new injury, but that the injury was the same and the symptoms had shifted from right to left, but the MRI was quite clear and unequivocal, revealing as it did the same source of the extruded material, which was in the right paracentral region of the annulus (RX 1).

Petitioner filed his Application for Adjustment of Claim on April 29, 2011. (AX 2)

Petitioner testified that he liked Dr. deGrange and elected to proceed with him regarding surgery. Dr. deGrange performed surgery on Petitioner on May 10, 2011, in Creve Coeur, Missouri. Petitioner underwent a microdiskectomy on the left at L4-5. (PX 3)

Petitioner was re-examined by Dr. deGrange on May 23, 2011. Petitioner advised the doctor he was doing quite well and his leg felt "great." Physical therapy was ordered and Petitioner was advised to remain off work. (PX 7)

Petitioner presented to Jersey Community Hospital for a physical therapy evaluation as requested by Dr. deGrange on May 25, 2011. Petitioner was reporting muscle tightness, postural problems, weakness, and pain. Petitioner described two accidents – one on November 6, 2010 when he was picking up a lawn mower and another one in February of 2011 when he fell at work. Petitioner reported general low back soreness and random left leg give-away. Petitioner was using a cane and reporting some difficulty sleeping in bed.

Dr. deGrange re-examined Petitioner on June 27, 2011 noting complete resolution of Petitioner's leg pain with only back pain continuing to be a problem. Petitioner's activities of daily living were becoming much easier to perform, that Petitioner's lower extremity radicular symptoms had resolved, and that Petitioner now only had back pain (PX 7, p. 8) Dr. deGrange noted that Petitioner still had some functional deficits and needed extended physical therapy before Petitioner can return to his very heavy lifting demand in the coal mines, but gave Petitioner a restricted work slip of 25 pound lifting limit, intermittent sit, stand, and walk, and no repetitive bending or twisting at the waist (PX 7, p. 8, 13. PX 3)

Respondent was able to accommodate Petitioner's restrictions and Petitioner returned to modified duty on July 11, 2011.

Petitioner attended regular therapy sessions through July 14, 2011. Petitioner reported he had returned to light duty work and was doing "fine." He believed he would be returning to full duty on July 25, 2011. He denied any difficulty with activities at home although he had not yet tried pushing his lawn mower to mow the lawn. Petitioner experienced occasional stiffness but was otherwise "okay" and denied any problems with sleep, exiting or entering his car, or driving. Petitioner had met all therapy goals and was discharged to an independent home exercise program. (PX 7)

At the July 25, 2011 visit Dr. deGrange noted Petitioner had returned to work with modifications and was doing well. Respondent was honoring his restrictions and Petitioner's leg was completely better and his mechanical back pain "improved." Petitioner still had symptoms with certain activities and assignments; however, Petitioner was not taking any medications. Petitioner was recovering from a bad spider bite on his right ankle and needed to keep his ankle elevated. Dr. deGrange believed Petitioner would be ready to return to his regular job on August 8, 2011. In the interim he could return to restricted duty on July 28, 2011 (25 lb. lifting limit). (PX 3)

Petitioner returned to regular duty on August 8, 2011 and has continued to work in that capacity. Petitioner also testified that he has worked overtime and often does so six days per week.

Petitioner returned to see Dr. deGrange on September 12, 2011. Petitioner's spider bite had completely resolved and Petitioner had returned to work but wasn't yet back to what he normally did. Petitioner was still noting occasional mild back ache and admitted he wasn't being diligent and consistent in his home exercise program. Petitioner reported that his radicular symptoms had completely resolved and he was not having any "significant" problems. Except for a rare Vicodin once every two weeks, Petitioner was medicine free. Petitioner's exam was good. He was advised he could safely return to his regular duties and was discharged from care with instructions to return if needed. He was also encouraged to be consistent with his exercises in light of his young age and expected work life. (PX 7)

Petitioner acknowledged that Dr. deGrange told him to return if he had any problems and Petitioner has not returned to see him since September 12, 2011.

Petitioner testified that he is earning his same rate of pay plus any negotiated increases. He occasionally experiences some soreness and discomfort in his back for which he exercises, uses ice or takes ibuprofen. He denied any ongoing soreness or stiffness in his legs. Petitioner also testified that he does some things "differently" and doesn't lift as much "heavy stuff." He performs his roof bolting activities "pretty okay."

Dr. Pineda's deposition was taken on October 3, 2012. Dr. Pineda is an orthopedic surgeon licensed to practice medicine in the State of Illinois and has board certifications in general orthopedic surgery and then spine surgery (PX 8, p. 4-5). Dr. Pineda saw Petitioner initially on March 21, 2011, and had the films of the MRI taken in December of 2010 available to him, which Dr. Pineda interpreted as showing a large herniation at L4/5 that was off to the right with a small left-sided component but with no specific effacement of any nerve root on either side (PX 8, p. 6-8, 31). Dr. Pineda did not expect there to be any or minimal left-sided lower extremity complaints by Petitioner given what he saw on the MRI of December of 2010 (PX 8, p. 8).

Dr. Pineda explained that given the herniation that was present on the MRI of December of 2010, there was going to be an annular tear, because in order to have a herniation, there must be an annular tear, and that the annular tear had to be on the posterior margin of the annulus but could not say for

certain if the tear was right of center or central (PX 8, p. 9-10). Dr. Pineda further explained that there is a correlation between the size of the annular tear and the herniated disc material that is present, in that the larger the annular tear, the higher the risk of herniation and the higher the risk of recurrent herniation (PX 8, p. 10-11). Dr. Pineda explained that there is also a correlation between the size of the disc material that herniates and the size of the annular tear (PX 9, p. 12). Dr. Pineda opined that based on the findings of the MRI of December of 2010, and assuming that a surgeon had recommended surgery to the individual with those findings as shown on the MRI of December of 2010, he would not have recommended a left-sided discectomy for several reasons, including that the disc material was primarily on the right, the pain experienced by the individual was primarily on the right, and then because the individual had a new symptom postdate the MRI of December of 2010 (PX 8, p.12). Dr. Pineda opined that given the findings on the MRI of December of 2010, the appropriate conservative treatment would have been medications, including Prednisone, exercises, and possibly epidural injections (PX 8, p. 14). Dr. Pineda explained that the purpose of Prednisone and the epidural injections is to shrink any inflammation off the nerve and eliminate the leg pain and that the steroid does not alter or change the annular tear but may insubstantially shrink the herniated disc material (PX 8, p. 15-17).

Dr. Pineda was aware at the time he initially examined Petitioner that there had been two accidents, one in November of 2010 and one in February of 2011, that the MRI of December of 2010 had occurred after the accident in November of 2010, and that Petitioner had received treatment after the accident of November of 2010, that significantly improved his right leg pain (PX 8, p. 17-18). Dr. Pineda was also aware that at the time of his initial examination of Petitioner, Petitioner was experiencing pain in both his legs (with the left leg being more involved) and worsening pain in his low back (PX 8, p. 18-19). On physical examination of Petitioner, Dr. Pineda found no nerve deficits and good muscle strength and sensation in Petitioner's legs. He explained that there can be nerve root compression that causes a symptom of pain, but may not necessarily cause enough irritation to block function in the sense of loss of movement of the extremity or that may have been initially and then it may have improved after a day or two (PX 8, p. 20). Dr. Pineda explained that he ordered a repeat MRI of the lumbar spine because there was a changed symptom set (PX 8, p. 20).

Dr. Pineda reviewed the actual films from the MRI that was performed on March 25, 2011, and interpreted it as showing a very large herniation that was bilateral causing root impingement on both the right and left sides (PX 8, p. 20). Dr. Pineda did not really compare the annular tears that were shown on the two MRIs but the two MRIs were different in that the lesion appearing on the MRI of March 25, 2011, was now incorporating a significant problem on both sides (PX 8, p. 22). Dr. Pineda also thought that the radiologist who compared the two MRIs was noting a change or an increase in the size of the herniation (PX 8, p. 24). Dr. Pineda opined that the increase in the size of the herniation as shown on the MRI of March 25, 2011, was related to the fall Petitioner had on February 28, 2011, because of Petitioner's increased symptoms and the nature of the symptoms being bilateral (PX 8, p. 24-25). Dr. Pineda recommended that Petitioner undergo a discectomy on both sides since the lesion was large and not amenable to a single-sided exposure (PX 8, p. 25).

Dr. Pineda diagnosed Petitioner with an L4/5 left-sided herniated disc and again opined that the work accident of February 28, 2011, aggravated the herniated disc material present at L4/5 as shown on the MRI of December of 2010 (PX 8, p. 26-27). The basis for this opinion was the change in Petitioner's subjective complaints as well as the change in the two MRIs (PX 8, p. 27). Dr. Pineda also opined that the work accident of February 28, 2011, was a contributing cause in the medical services that were rendered to Petitioner by himself and Dr. Western after February 28, 2011 (PX 8, p. 27). Dr. Pineda also opined that assuming no change in Petitioner's condition of ill-being after he last saw Petitioner, the surgery

Petitioner underwent on May 10, 2011, was related to the work accident of February 28, 2011 (PX 8, p. 29-30).

Dr. Pineda acknowledged that Dr. Western's clinic note of February 28, 2011, noted that Petitioner complained of right leg symptoms of pain and weakness but no numbness or tingling and that it was difficult to bear weight particularly on the right leg (PX 8, p. 32). Dr. Pineda also acknowledged the clinic note of MOHA for February 28, 2011, noted Petitioner had right leg symptoms but that there was something that had an L circled in a handwritten note and that the straight leg raising test on the left was negative and positive on the right (PX 8, p. 32-33). Dr. Pineda acknowledged that he did not review any records of Petitioner's primary physician, Dr. Schleeper, or the chiropractor (PX 8, p. 35). Dr. Pineda also acknowledged that in his clinic note of March 21, 2011, he advised Petitioner that he could not tell him who would be responsible for his condition at that point in time and that he wrote an addendum that causality may be an issue here, but he noted that Petitioner now had more diffuse pain that really incorporated not only the right side but more so the left side (PX 8, p. 36-37).

Dr. Pineda acknowledged that microdiscectomies do less physical damage or cause less instability than foraminotomies or laminectomies because less bone is taken out and there is a small amount of tissue that is interrupted (PX 8, p. 38). Dr. Pineda also acknowledged that he did not know if Petitioner's disc herniation became larger because the MRIs were not tied around the accidents, and then acknowledged that the herniation could have happened at any time between the first and second MRIs (PX 8, p. 39). Dr. Pineda did think that there was only one annular tear where all the herniation was occurring and acknowledged that once there is a tear and disc material has extruded, then it is much easier for additional disc material to be extruded and that can actually occur by bending over to your shoes or sneezing or having a bowel movement (PX 8, p. 39-30). Dr. Pineda noted that an individual would experience pain with the extruded material depending on the size of the extrusion and opined that given the degree of herniation as shown on the MRI of March of 2011, he would expect that there would be pain experienced by Petitioner (PX 8, p. 44-45). Dr. Pineda did not recall seeing anything in any of the medical records where Petitioner described tying his shoes, sneezing, or having a bowel movement when he noticed increased pain in his lumbar spine and/or right or left legs (PX 8, p. 45).

Dr. Pineda further explained that the reason for surgeries on the disc is to free the nerve root and make the patient comfortable (PX 8, p. 40-41). Dr. Pineda acknowledged that there are a select group of people who advocate annular repair but that is an inordinately difficult task as the annulus will usually scar down and heal itself once whatever was pushing it open is gone (PX 8, p. 41-42).

Dr. Pineda further explained that the pain table involved with a herniated disc is that it starts with back pain and then the disc material extrudes or comes out and this process can occur over a 24 hour period when the material hits the nerve root and then the nerve root becomes inflamed (PX 8, p. 48). Dr. Pineda further noted that when Dr. Western examined Petitioner on March 7, 2011, the physical examination showed a positive straight leg raise on both sides (PX 8, p. 49). Dr. Pineda also opined that he expected Petitioner's complaints to go back and forth between both extremities given the findings as shown on the MRI of March of 2011, depending on how much favoring Petitioner did of one side or the other (PX 8, p. 50).

Dr. Pineda acknowledged that the disc extrusion can be a very gradual process but that usually the pain is going to follow the gradation (PX 8, p. 53-54). Dr. Pineda also acknowledged that the disc extrusion may well have increased in size between February 28, 2011 and the date of the MRI in March of 2011, but he would have expected there to be a progressive worsening of complaints in that situation (PX

8, p. 55). Dr. Pineda also acknowledged that if additional material had extruded between the work accident on February 28, 2011, and when the MRI was performed in March of 2011, then he would have expected a change in the symptoms (PX 8, p. 55-56).

Respondent's Exhibit 2 contained an Accident & Sickness Claim Group Insurance form dated September 7, 2010, an Attending Physician's Statement dated September 3, 2010, an Attending Physician's Statement dated November 19, 2010, an Accident & Sickness Claim Group Insurance form dated April 24, 2011, and an Attending Physician's Statement dated May 10, 2011. The Accident & Sickness Claim Group Insurance form completed by Petitioner and dated September 7, 2010, noted that Petitioner had low back pain, that the claim was related to other accident, the date of onset was August 29, 2010. The Attending Physician's Statement dated September 3, 2010, was completed by Dr. Schleeper and noted the diagnosis was lumbosacral strain and the condition was not due to injury or sickness arising out of patient's employment. The Attending Physician's Statement dated November 19, 2010, was also completed by Dr. Schleeper and noted that the diagnosis was LS muscle strain with radiculopathy right leg and the condition was not due to injury or sickness arising out of patient's employment. The Accident & Sickness Claim Group Insurance form completed by Petitioner and dated April 24, 2011, noted that Petitioner had lower back pain, that the claim was related to a work accident and another accident, and that the dates of onset were November 6, 2010 and February 28, 2011. The Attending Physician's Statement dated May 10, 2011, was completed by Dr. deGrange and noted that the diagnosis was HNP L4/5 and the condition was not due to injury or sickness arising out of patient's employment. Respondent's Exhibit 3 contained attendance calendars for Petitioner for the years 2005-2013.

The Arbitrator concludes:

1. Petitioner's condition of ill-being is causally related to the work accident of February 28, 2011. The sequence of events supports this as does the credible medical evidence. The undisputed evidence shows that whatever low back pain Petitioner had experienced since he was about 20 years of age, had been either diagnosed as scoliosis, low gluteal spasm, or lumbosacral strain. The diagnosis of lumbosacral strain had been made by Dr. Schleeper as late as September 3, 2010, when she completed the Attending Physician's Statement for Petitioner to be off work at that time (RX 2). Petitioner sustained a non-work-related accident in November of 2010 when he was pulling a lawn mower out of his garage, and subsequent to that accident, Petitioner had complaints of low back pain and right leg pain. Neither the medical records of Carlinville Chiropractic Clinic nor Dr. Western, with whom Petitioner treated for his condition of ill-being following the accident in November of 2010, describe the nature of the right leg pain to be numbness, tingling, or weakness -- only pain. There was no specific location of the pain in Petitioner's right leg. Petitioner underwent an MRI of the lumbar spine on December 28, 2010, that revealed a large right subarticular disc extrusion at L4/5 causing severe right lateral recess stenosis and effacement of the descending right L5 nerve root, but no displacement of the nerve root (PX 3, p. 7). The undisputed evidence further shows that Petitioner underwent a course of conservative treatment, including epidural injections and a one-time evaluation by physical therapy, that caused Petitioner's complaints of low back pain and right leg pain to significantly improve, and that Petitioner returned to light duty work that required him to be on his feet all day and perform a lot of bending and twisting without any difficulties. Petitioner was intending to be released to full duty work as of March 1, 2011, when Petitioner sustained the work accident of February 28, 2011.

Immediately following the undisputed February 28, 2011 work accident, Petitioner had severe low back pain, weakness of his right leg, and right foot pain that Petitioner described as numbness (PX 4, p. 2,3, 7). X-rays taken at that time showed loss of the normal lordosis that may have been related to patient positioning or muscle spasm, and Petitioner received injections in the left and right upper gluteal areas. The severity of the pain Petitioner experienced after the work accident of February 28, 2011, was also noted by Dr. Western and Springfield MOHA, who examined Petitioner after he had been to St. John's Hospital and had been administered the injections into his left and right upper gluteal areas. The undisputed evidence also shows that Petitioner was not even able to ambulate at the time of these visits without the use of a wheelchair. The medical records of Carlinville Chiropractic Clinic showed that Petitioner was seen the day after the accident of February 28, 2011, and had bilateral findings on physical examination. (PX 1, p. 17). The record of Dr. Western for March 7, 2011, also showed that Petitioner had a positive straight leg raise test on both the right and left sides at the time of that examination. When Petitioner initially saw Dr. Pineda on March 21, 2011, Petitioner was experiencing back pain and bilateral leg pain and that the back pain Petitioner experienced after the work accident was even more diffuse than what Petitioner had experienced before. The MRI performed on Petitioner on March 25, 2011, now showed a large central disc extrusion that had increased in size when compared to the study of December 28, 2010, that was now more broad-based and central, there was now moderate circumferential canal stenosis and displacement of both L5 nerve roots at the lateral recesses, and mild foraminal stenosis asymmetric to the right (PX 3, p. 20). Even Dr. deGrange, who initially examined Petitioner pursuant to Section 12 of the Act, noted that the second MRI showed that the disc material had now spread across the midline and was occupying both sides of the spinal canal symmetrically, despite the fact that the annular tear had not changed in location or size (RX 1).

The records of Springfield MOHA diagnosed Petitioner with a lumbar strain with exacerbation of a previous back injury when Petitioner was seen on the date of the work accident (PX 5, p. 11). Dr. Western, who saw Petitioner before and after the work accident of February 28, 2011, commented in his medical record of March 7, 2011, that while Petitioner did have a pre-existing disc herniation, it appeared to have been aggravated by the work accident. Dr. Western also completed an Attending Physician's Statement on March 7, 2011, that diagnosed Petitioner's condition of ill-being to be aggravation of disc herniation and answered affirmatively the question whether this condition was due to injury or sickness arising out of the patient's employment (PX 2, p. 59). In addition, Dr. Pineda's record of March 21, 2011, while noting that causality might be an issue here, commented that Petitioner's pain presentation was different after the work accident of February 28, 2011, and a reasonable inference from this statement is that the work accident was a factor in Petitioner's current pain presentation. Finally, at the time Dr. deGrange performed surgery on Petitioner on May 10, 2011, he noted in his operative report that a reason for the surgery was that the MRI revealed the presence for large disc herniations on the left at L4/5 (PX 7, p. 6). The only MRI that revealed such a finding was the one taken after the work accident and performed on March 25, 2011. While there must be an annular tear for there to be a herniation, it is the disc material that is addressed at the time of surgery and not the annular tear (PX 8, p. 40-42).

In addition, Dr. Pineda credibly explained and opined that the increase in the size of the herniation as shown on the second MRI was related to the work accident Petitioner sustained (PX 8, p. 24-25). Dr. Pineda also opined that the work accident of February 28, 2011, aggravated the herniated disc material present at L4/5 as shown on the MRI of December of 2010 (PX 8, p. 26-

27). The opinion of Dr. deGrange that the work accident was not an injury arising out of and in the course of Petitioner's employment because there was no new breach or rupture of the annulus was not persuasive regardless of the fact Petitioner chose to have Dr. deGrange perform his surgery. Dr. deGrange contradicted himself when he concluded that Petitioner had similar subjective complaints but then went on to acknowledge that Petitioner had symptoms now in his left leg, whereas previously they were only in the right leg. In addition, Dr. deGrange acknowledged that the disc material as shown on the second MRI had changed from the first MRI, even though the annular tear had not.

2. Medical bills incurred by Petitioner in treatment of his condition of ill-being and found in Petitioner's Exhibit 9 were reasonable and necessary as Respondent's only objection to these bills was on liability grounds. Given the finding on causation, Respondent is liable for these bills.

3. Petitioner was temporarily totally disabled from March 1, 2011 through July 10, 2011, representing 18 6/7 weeks. Respondent agreed to this period of temporary total disability, but disputed liability for it. Given the finding on causation, Respondent is liable for the period of temporary total disability.

4. Petitioner's condition of ill-being was diagnosed as an L4/5 left-sided herniated disc and Petitioner initially underwent an epidural injection for his condition of ill-being, and then ultimately, an L4/5 lumbar microdiscectomy on the left. Surgery provided Petitioner with resolution of his lower extremity pain and near resolution of his low back pain and Petitioner was able to return to his job as a roof bolter for Respondent. However, even Dr. deGrange expressed concern for Petitioner's condition of ill-being, recommending that Petitioner continue with his home exercise program, at least four times per week, given Petitioner's young age and amount of work left in his adult life. Petitioner is permanently partially disabled to the extent of 20% person as a whole.

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14IWCC0384

14IWCC0384

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☒ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Meridee Bitler,

Petitioner,

vs.

NO: 06 WC 06637

14IWCC0385

River Band School District,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of average weekly wage, prospective medical treatment, temporary total disability benefits and penalties and fees and being advised of the facts and law, modifies the Decision of the Arbitrator on the issue of prospective medical treatment as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The Arbitrator found that Petitioner failed to prove by a preponderance of the credible evidence that the prospective treatment, an exploratory arthroscopy by Dr. Bach, is causally related to Petitioner's left knee injury. Dr. Bach deferred a causal connection opinion until after the arthroscopy. Dr. Bach testified that he believes scar tissue has developed within the knee as a result of the accident and subsequent surgical treatment. In Dr. Bach's opinion, scar tissue is most likely responsible for Petitioner's ongoing symptoms. He believes an arthroscopic evaluation is appropriate where conservative measures have failed and Petitioner continues to

complain of significant symptoms and functional difficulties. When questioned whether radiologic evidence shows the presence of scar tissue within the knee, Dr. Bach testified that diagnostic films do not show the scar tissue. He testified that because he cannot be certain in advance of surgery whether it definitively exists, he does not know whether any ameliorative procedures will be performed during the arthroscopy or whether the arthroscopy will merely allow him to ascertain what, if any, progression of Petitioner's underlying degenerative condition has occurred since the last surgery he performed.

We find the diagnostic surgery recommended by Dr. Bach to be reasonable and necessary treatment intended to cure or relieve the effects of the September 1, 2004 accident and we do not agree that it may not be authorized merely because it is exploratory. Respondent's Section 12 examiner, Dr. Raab, opined that the treatment rendered to Petitioner by Dr. Bach has been excellent. He agrees that an exploratory arthroscopy is a reasonable option, although he has already reached the opinion that Petitioner's ongoing symptoms are the result of degenerative changes in the patellofemoral joint. Clearly some degree of left knee arthritis pre-dated the September 1, 2004 accidental injury; Petitioner has a history of arthroscopies in 1991 and 1994. There are no records from these procedures in evidence and Petitioner's testimony that she sought no treatment for her left knee between 1994 and the date of accident was not contradicted. Respondent accepted the September 1, 2004 accident as compensable and authorized treatment including a chondroplasty and Fulkerson osteotomy performed by Dr. Bach. We rely on Dr. Bach's opinion that additional treatment is necessary and offers a reasonable expectation of improving Petitioner's condition whether by removing scar tissue related to Petitioner's injury that may be generating pain or by allowing Dr. Bach to assess Petitioner's degenerative condition.

All else is otherwise affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the decision of the Arbitrator filed September 4, 2012 is modified as stated above and otherwise affirmed and adopted; specifically the Arbitrator's findings with respect to the disputed issues of average weekly wage, temporary total disability benefits and penalties and fees.

IT IS FURTHER ORDERED BY THE COMMISSION shall pay to the Petitioner the sum of $201.61 per week for a period of 26 and 5/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay reasonable and necessary medical services, including the prospective treatment recommended by Dr. Bach, pursuant §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 2 7 2014
RWW/plv
o-3/25/14
46

Ruth W. White

Charles J. DeVriendt

Daniel R. Donohoo

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) DECISION OF ARBITRATOR

BITLER, MERIDEE
Employee/Petitioner

Case# **06WC006637**

RIVER BAND SCHOOL DISTRICT UNIT DISTRICT #2
Employer/Respondent

14IWCC0385

On 9/4/2012, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.14% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

2028 RIDGE & ASSOC PC
JOHN E MITCHELL
415 NE JEFFERSON AVE
PEORIA, IL 61603

1120 BRADY CONNOLLY & MASUDA PC
PETER J STAUROPOULOS
ONE N LASALLE ST SUITE 1000
CHICAGO, IL 60602

14IWCC0385

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

MERIDEE BITLER,
Employee/Petitioner

v.

RIVER BEND SCHOOL DISTRICT UNIT DISTRICT #2,
Employer/Respondent

Case # **06** WC **06637**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen H. Pulia**, Arbitrator of the Commission, in the city of **Peoria**, on **4/19/12, 6/11/12 and 8/7/12**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☒ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, **9/1/04**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident through 1/7/10.

In the year preceding the injury, Petitioner earned **$15,120.48**; the average weekly wage was **$302.41**.

On the date of accident, Petitioner was **47** years of age, ***married*** with **0** dependent children.

Respondent ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$33,102.32** for TTD, **$00.00** for TPD, **$00.00** for maintenance, and **$00.00** for other benefits, for a total credit of **$33,102.32**.

Respondent is entitled to a credit of **$00.00** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $201.61/week for 26-5/7 weeks, commencing 12/14/04 through 1/25/05, and 9/9/08 through 1/30/09, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services outlined in Section J of this decision, as provided in Sections 8(a) and 8.2 of the Act.

Petitioner's claim for prospective medical expenses is denied.

Respondent shall pay to Petitioner penalties of **$00.00**, as provided in Section 16 of the Act; **$00.00**, as provided in Section 19(k) of the Act; and **$00.00**, as provided in Section 19(l) of the Act.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

8/31/12
Date

ICArbDec19(b)

SEP - 4 2012

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 47 year old school secretary sustained an accidental injury that arose out of and in the course of her employment by respondent on 9/1/04. Petitioner testified that at the end of the school day there was a kindergarten student that had missed the bus. Petitioner contacted the driver and took the student by the hand and headed towards the bus. As she got to the grassy edge of the ground she thought her left knee hit a gopher hole and she felt her left knee pop. Prior to this accident petitioner had two prior arthroscopic surgeries to her left knee, with the most recent being 10 years ago.

On 9/17/04 petitioner presented to Dr. Tuvi Mendel for evaluation of her left knee. She noted an increase in pain and discomfort since 9/1/04 when she was running over a patch of grass after school and twisted her left knee and felt pain. Since then she has complained of left knee pain of a 6 to 7 on a scale of 10. She denied any major locking, catching, or giving way but complained of moderate tenderness medially. Petitioner gave a history of her two prior surgeries to her left knee and stated that before 9/1/04 she had not had any significant difficulties since the last surgery in 1994. She reported difficulty going up and down stairs, squatting, and kneeling. She stated that her symptoms had slightly improved but she still has discomfort and pain. Following an examination and x-rays Dr. Mendel assessed a left knee twisting injury and possible medial compartment pathology. Dr. Mendel instructed her on appropriate quad strengthening exercises, anti-inflammatories, and possible bracing. Dr. Mendel injected her left knee joint.

On 10/6/04 petitioner followed-up with Dr. Mendel. She reported that the injection did not significantly improve her symptoms. Following an examination and x-rays Dr. Mendel noted that petitioner was somewhat young for a total knee replacement, but will require one. He indicated that other types of management include arthroscopy evaluation and management of possible articular damage with the ability to stage the knee and evaluate the knee for possible future management. Petitioner chose to proceed with the arthroscopy. On 10/20/04 Dr. Mendel recommended an aggressive course of physical therapy and a Palumbo brace to help with her symptoms until she had an evaluation by workers' compensation and decided on a further course of management.

On 11/24/04 petitioner underwent a Section 12 examination performed by Dr. Stephen Weiss at the request of the respondent. In addition to an examination, Dr. Weiss performed a record review. Petitioner noted that she underwent 2 arthroscopies of her left knee in 1991 and 1994, and did excellently after the 2nd operation. She gave a consistent history of her accident on 9/1/04 and her treatment to date. She stated that she wanted to undergo surgery because her knee was painful. She reported pain most of

the time and especially when weightbearing, twisting and bending or squatting. A physical examination revealed slight thigh atrophy and a small but definite effusion in the left knee. Dr. Weiss diagnosed status post prior arthroscopies of the left knee, 1991 and 1994; early post-traumatic/degenerative arthritic changes of the left knee; and aggravation of above secondary to incident on 9/1/04. Dr. Weiss was of the opinion that petitioner suffered some degree of intraarticular injury as a result of the injury on 9/1/04. Dr. Weiss was not as certain as Dr. Mendel that petitioner would definitely require a total knee replacement. He agreed with the arthroscopy recommended by Dr. Mendel. He opined that this surgery is related to the injury on 9/1/04, and that the injury on 9/1/04 caused a permanent aggravation of her preexisting condition. He was of the opinion that petitioner could perform full work activities until she undergoes the arthroscopy. He further indicated that she should try and avoid kneeling or squatting where possible.

On 12/1/04 petitioner returned to Dr. Mendel. He was of the opinion that a lot of her pain was the result of probable wear or possible articular cartilage injury of the medial compartment status post two knee scopes in the past with a probable meniscectomy. It was decided that petitioner would proceed with surgical intervention.

On 12/14/04 petitioner underwent a left knee arthroscopy with patellofemoral compartment chondroplasty. This procedure was performed by Dr. Mendel. Petitioner followed up post-operatively with Dr. Mendel. Her treatment included a course of physical therapy.

On 12/22/04 Dr. Mendel continued petitioner in physical therapy and released her to light duty work with restrictions on sit-down duty only work with no heavy lifting. On 1/12/05 Dr. Mendel noted that petitioner was doing well. She complained of occasional aches and pains as it relates to her patellofemoral joint. Dr. Mendel noted petitioner was back working full duty and was doing well. He released petitioner from his care. He instructed petitioner to continue to use care as it relates to her knee, avoid squatting and kneeling, avoid impact activity and concentrate on quad strengthening, bracing and anti-inflammatories as needed, and swimming and biking type activities.

Petitioner testified that she returned to work in January of 2005. She stated that she worked until 6/20/05. She further testified that she received sick pay for the time she was off, and did not receive any temporary total disability benefits.

On 1/12/05 petitioner followed up with Dr. Mendel. She was doing well with complaints of occasional aches and pain as it related to her patellofemoral joint. She stated that she was back performing her full duties and overall was doing well. Dr. Mendel released her from his care and to full

duty work. He recommended that she continue to use care as it relates to her knee, avoid squatting, kneeling, and impact activity and concentrate on quad strength, bracing, anti-inflammatories as needed, and swimming and biking type activities.

On 6/27/05 petitioner returned to Dr. Mendel. Petitioner reported difficulties mainly as it relates to patellar tendonitis, mild patellofemoral discomfort and irritation over the medial portal site. She also complained of occasional tightness and swelling throughout the day. Dr. Mendel examined petitioner and took some x-rays. He noted that they showed moderate wear on the undersurface of the patella. He fitted petitioner for a Palumbo brace and prescribed anti-inflammatories. He also injected the portal side of the left knee. He fitted her with a patellar tendon strap per physical therapy.

On 11/18/05 petitioner returned to Dr. Mendel. She reported about 50% improvement for a month following the injection on 6/27/05. She was also using the brace as needed. She complained of difficulties as it relates to patellofemoral type problems, squatting, kneeling, and bowling. An examination revealed pain, patellofemoral in nature with crepitus and discomfort. X-rays were taken that revealed left knee patellofemoral wear. Dr. Mendel recommended continued conservative management including bracing, anti-inflammatories, and chondroitin sulfate. He was also of the opinion that a Hyalgen injection would not be unreasonable. Operative management was discussed that could include a Maquet type tibial osteotomy. Dr. Mendel settled on a Hyalgen injection after approval was received.

On 5/31/06 petitioner returned to Dr. Mendel. Petitioner complained of patellofemoral pain and discomfort that affects her daily activities. She was unable to walk or do any type of recreational activities like she was able to do in the past. She reported difficulty going up and down the stairs. She reported occasional pain worse than what she had before surgery. Following an examination Dr. Mendel recommended another Hyalgen injection. Petitioner underwent the repeat Hyalgen injection. She reported 40% relief with the series of injections. On 7/5/06, 7/12/06 and 7/19/06 Dr. Mendel performed additional Hyalgen injections into the left knee joint. On 7/19/06 petitioner was still having some difficulties with regards to squatting and kneeling. The scope pictures revealed slight wear on the undersurface of the patella. She stated that she continues to use the brace and do aggressive quad strengthening. Petitioner reported that she had a new job as a bank teller and noted an increase in pain since she started doing a lot more standing.

On 8/30/06 petitioner followed-up with Dr. Mendel. She reported no significant improvement. She continued to complain mainly of patellofemoral type discomfort and pain. Dr. Mendel noted that petitioner was somewhat young and still active but was getting to the point that she is not even able to get

in and out of a chair secondary to pain and discomfort. An examination revealed that most of her symptoms were related to the patellofemoral joint. The patellofemoral joint on the x-ray revealed significant wear of the undersurface. Dr. Mendel assessed left knee residual patellofemoral pain secondary to wear. Continued conservative treatment versus operative intervention was discussed. Petitioner indicated that she would think about it.

On 4/18/07 petitioner returned to Dr. Mendel complaining of moderate discomfort and pain, difficulties with daily activities and moderate irritability as it relates specifically to her patellofemoral joint. Dr. Mendel was of the opinion that conservative treatment had not resolved her complaints and recommended a patellofemoral replacement. He did not recommend a full knee replacement, cartilage replacement, or tibial tubercle transfer. Dr. Mendel noted that petitioner's case was submitted to Dr. Gause who did not agree with his recommendation. Dr. Mendel took offense with Dr. Gause's remark that he was not available to discuss petitioner's case. He noted that he had made arrangements through his office staff to contact Dr. Gause to discuss petitioner's case. He further noted that at that time he was told by Dr. Gause's staff that he was not available. Dr. Mendel indicated that at that point he addressed his staff to call him back, which they tried to do to make another appointment, and Dr. Gause's office did not follow through. Dr. Mendel indicated that he did not necessarily disagree with Dr. Gause that although there are not a lot of indications for patellofemoral replacement, there have been reasonable results and the procedure is becoming more popular, but it is only reserved for a few patients that meet the strict criteria after failure of extensive attempts or other modalities. Dr. Mendel indicated that he would continue to treat the petitioner conservatively.

On 5/14/08 petitioner underwent a Section 12 examination performed by Dr. Bernard Bach, at the request of the respondent. In addition to an examination, Dr. Bach performed a record review. Petitioner reported patellofemoral symptoms with pain she described as a "needle type sensation" in the kneecap area. She reported discomfort with prolonged sitting and pain with stairs. She stated that she takes 6-8 Advil a day. Dr. Bach noted that Dr. Mendel was recommending a McKay osteotomy. Following an examination and x-rays, Dr. Bach assessed recalcitrant petallar pain of the left knee status post arthroscopy. Dr. Bach noted an increased Q-angle which was preexistent and which is a risk factor for patellofemoral symptoms. He was of the opinion that her treatment to date was reasonable. He was further of the opinion that petitioner was a candidate for a Fulkerson anteromedialization proximal tibial osteotomy over a McKay type tibial osteotomy. He was of the opinion that a McKay type tibial osteotomy can realign the extensor mechanism as well as off load the patellofemoral mechanism. He

noted no symptom magnification or malingering and was of the opinion she would benefit from a Fulkerson anteromedialization. He further opined a causal connection between her symptoms and the injury on 9/1/04. What Dr. Bach could not elicit from the injury mechanism was whether the meniscal tear itself was a solo injury or in fact she had had some mild component of a patellar subluxation with preexistent chondromalacia. He was of the opinion that the chondromalacia of the patellofemoral compartment was most likely preexistent.

On 9/9/08 petitioner underwent a left knee arthroscopic lateral release and Fulkerson AMZ, proximal tibial osteotomy. This procedure was performed by Dr. Bach. The post-operative diagnosis was left knee patellar pain. Dr. Bach authorized petitioner off work. Petitioner followed up post-operatively with Dr. Bach on 9/10/08, 9/19/08, 10/6/08 and 10/20/08. On 10/20/08 petitioner was doing well. Dr. Bach's impression was status post left knee Fulkerson AMZ osteotomy and lateral release for patellofemoral malalignment syndrome. Dr. Bach was of the opinion that petitioner could discontinue her brace, and progress to weight bearing as tolerated using her crutches for safety. He prescribed physical therapy and released her to full duty work with restrictions of sedentary work only.

On 12/1/08 petitioner last followed-up with Dr. Bach. Petitioner reported that she was improving with physical therapy. She reported occasional pain in the mid to superior region of the left tibia. Petitioner had been walking with a cane but had not been able to return to work because there was no sedentary work available at her job. Following an assessment Dr. Bach was of the opinion that she was doing quite well and should continue to participate in physical therapy. He was further of the opinion that petitioner could return to work with sedentary duty, standing no longer than 15 minutes at a time, no kneeling, squatting or crawling and only occasional stairs.

On 1/12/09 Dr. Bach released petitioner to sedentary work only with no standing or walking for greater than 2 hours at a time, and no climbing stairs/ladders. On 1/20/09, 2/23/09 and 4/6/09 petitioner followed-up with Dr. Bach. On 1/30/09 Dr. Bach drafted a script indicating that petitioner could return to work full duty without restrictions. Petitioner testified that she did not see Dr. Bach on this date. On 2/23/09 Dr. Bach again released petitioner to return to full duty work without restrictions.

On 2/9/09 petitioner began work for an optometrist. She testified that the job was that of a receptionist and she thought all she had to do was sit and take phone calls and check patients in. Petitioner testified that the job was actually different than she thought. She testified that it involved alot standing, and she did filing in the record room that required squatting, and kneeling for records that were low, and climbing a ladder to get to records that were high. Petitioner testified that she also had to walk

patients to the examination room. She estimated that she had to stand 50% of the time. Petitioner quit this job on 2/27/09. When she left the job she testified that she had increased pain in her knee and it started affecting her ankle.

On 4/6/09 petitioner reported that she recently had to leave her job as a file clerk in an optometrist office due to significant pain she was having in her ankle and peroneal tendons. She stated that she had dramatically improved over the past 6 weeks. She stated that she did not have any significant complaints in regards to her knee and her Fulkerson osteotomy. She reported some mild pain at the distal portion of her incision. Following an examination Dr. Bach was of the opinion that petitioner should continue in physical therapy. Dr. Bach released her on an as needed basis.

Petitioner testified that she was in physical therapy from January of 2009 through 4/6/09. While in physical therapy petitioner had trouble balancing. She stated that she was treated with heat and ice and the therapists would use their hands to relax the muscles around her knee and the tendons in her ankle.

On 9/9/09 Dr. Bach drafted a letter to petitioner's attorney in response to his letter dated 8/31/09. He clarified that when he last saw her on 4/7/09 she was already working at a full duty capacity with no restrictions. He was of the opinion that she could continue to do so.

On 1/7/10 petitioner underwent a Section examination performed by Dr. Debra Zillmer, at the request of the respondent. Petitioner complained of pain over the anterior, anteromedial and anterolateral aspect of her left knee that occurs with activity such as standing for longer than three hours, sitting for a lengthy period of time in a car traveling (greater than an hour), descending stairs, rising from a sitting position and particularly rising from the floor. She also felt there was "something crawling" over the anterior aspect of her knee intermittently. She stated that the discomfort caused her to discontinue a recent job because of its significant effect on her. Following an examination and record review, Dr. Zillmer's impression was left knee patellofemoral pain and chondrosis, which does have a bearing on quality of the patient's activities of daily living and her ability to function in a work situation with frequent rising from a seated position and prolonged standing. Dr. Zillmer was of the opinion that petitioner's condition had improved since the patellar realignment, but she still remains symptomatic.

Dr. Zillmer was of the opinion that petitioner's prognosis was fair. She opined that a causal relationship of the condition to her injury exists, and her work-related injury did permanently exacerbate a pre-existing condition. She noted that because petitioner did not get back to pre-injury status, operative intervention was performed to improve function and comfort. She was further of the opinion that

petitioner had reached maximum medical improvement and could return to work. Dr. Zillmer recommended a FCE and the limitations of her abilities be worked into her next job description.

Petitioner testified that she followed-up with Dr. Bach on 2/14/10 and discussed her restrictions. She stated that they discussed standing no more than 15-30 minutes. Petitioner testified that she could not perform her regular work duties for respondent with these restrictions. The credible evidence does not include any records from Dr. Bach for this date. Additionally, the medical bills of Midwest Orthopedics At Rush do not include any bills for this visit.

On 6/14/10 petitioner returned to Dr. Bach. She reported that at times she still continues to have pain. She complained of pain along the anterior knee, and pain localized as peripatellar. She reported that her pain is brought on by standing for long periods of time or walking long distances. She still noted pain when kneeling or squatting position. She noted small amounts of swelling after standing for long periods of time, which is anteriorly over the mid portion of her incision. Following an examination and x-rays, Dr. Bach's impression was 21 months status post Fulkerson osteotomy for patellar instability with patellar pain. Dr. Bach was of the opinion that petitioner's knee was stable and the patella was stable. He was of the opinion that she likely suffered a flare up of patellofemoral pain. Dr. Bach performed an injection and recommended additional course of physical therapy. Dr. Bach was of the opinion that petitioner could work a job with sedentary type activity with the opportunities to both sit, stand, and walk, but not for extended periods of time. He released petitioner on an as needed basis.

On 8/30/10 petitioner returned to Dr. Bach. She stated that the injection of 6/14/10 provided her no relief. She continued to complain of some pain going down stairs and with walking anterolaterally. She noted that she was much better than she was, but was still having some feelings of instability and pain. Dr. Bach examined petitioner and assessed some mild residual pain. He ordered an MRI to further evaluate the cause of her problem. He was of the opinion that she may very well have some scar tissue that is painful.

On 10/12/10 petitioner underwent an MRI of the left knee that showed a torn posterior horn of the medial meniscus that extends to the inferior intraarticular surface; a torn posterior horn of the lateral meniscus also extending to the inferior articular surface; very diminutive anterior horn of the lateral meniscus; and postoperative changes.

On 11/15/10 petitioner returned to Dr. Bach after the MRI of the left knee. Petitioner reported pain directly on her kneecap and lateral and medial to it. She reported some swelling at night and an

occasional feeling of a locking sensation in her knee and stated that it is very stiff going down stairs. Dr. Bach noted that the MRI showed a small trochlear defect. He saw no scarring in the fat pad, and noted bilateral meniscal signal changes. He was not convinced that this represented a tear. Dr. Bach was of the opinion that her pain was likely due to some patellofemoral symptoms and possibly a medial plica. Petitioner requested some physical therapy to see if it would improve her pain prior to an arthroscopy. Dr. Bach released petitioner on an as needed basis.

On 12/27/10 petitioner followed-up with Dr. Bach. Petitioner stated that the physical therapy was not really helping. She reported a fall three weeks ago that exacerbated her previous medial pain. Dr. Bach continued her in physical therapy and told her to take Celebrex. Dr. Bach was of the opinion that if this did not work surgery would be scheduled.

On 3/21/11 petitioner followed-up with Dr. Bach. It was noted that petitioner had refractory anteromedial left knee pain status post an anterior medialization procedure Fulkerson done approximately 1 ½ years ago. Petitioner followed-up after a trial of anti-inflammatories to try and quiet her inflammation down and begin with some new therapy. Petitioner stated that this did not significantly change her symptoms. She complained of ongoing complaints of significant pain particularly on the anteromedial aspect of her left knee as well as under her kneecap, particularly with activities such as stairs. Following an examination Dr. Bach's impression was left knee refractory anteromedial pain despite conservative measures including Celebrex and therapy. Dr. Bach recommended that petitioner proceed with the left knee arthroscopy to evaluate the patellofemoral compartment as well as excise the medial plica which appeared to be the source of her symptoms. Petitioner indicated that she wanted to proceed with the surgery.

On 7/11/11 petitioner underwent a Section 12 examination performed by Dr. David Raab, at the request of the respondent. In addition to an examination, Dr. Raab performed a record review. Following his examination and record review, Dr. Raab's impression was anterior knee pain, patellofemoral with associated patellofemoral chondrosis status post Fulkerson osteotomy. In response to the questions posed by respondent, Dr. Raab believed petitioner has continued complaints of anterior knee pain, patellofemoral in nature, with associated patellofemoral chondrosis and early degenerative arthritis of the patellofemoral joint status post Fulkerson osteotomy. Dr. Raab was of the opinion that petitioner had preexisting problems with her left knee prior to the work related injury of 9/1/04. He was of the opinion that the prior surgeries were for issues regarding the patellofemoral joint based on the operative reports, especially of the initial arthroscopic procedure subsequent to the reported work related injury of 9/1/04.

Dr. Raab was of the opinion that the petitioner demonstrated preexisting problems with the patellofemoral joint. Dr. Raab opined that there is certainly a possibility that petitioner's work related injury may have aggravated her pre-existing knee complaints, although it appears that the report of the injury is quite trivial. Dr. Raab was of the opinion that petitioner's treatment had been reasonable and necessary. Dr. Raab was of the opinion that a knee arthroscopy is reasonable. However, he did not feel this would be a long-term solution to her problem due to the degenerative changes of the patellofemoral joint which he believed was the etiology of her pain. He was of the opinion that a scope may give her some symptomatic short-term relief of pain, but her prognosis was guarded. He believed that petitioner would continue to have complaints of anterior knee pain in the future, patellofemoral in nature.

Dr. Raab was of the opinion that it seemed reasonable for the petitioner to have had an initial knee arthroscopy, but the second procedure, an osteotomy, is more so indicated for her chronic longstanding issues regarding her patellofemoral joint that he believed more likely than not would have occurred with or without the work related injury. Dr. Raab opined that it is reasonable to consider the Fulkerson osteotomy as definitive treatment for the work related event that occurred on 9/1/04, and subsequent to that event she was working in a full duty capacity. He also noted that subsequent to the surgery petitioner had resolution of her pain and was doing well. He opined that future treatment would be attributed to the natural history of the degenerative changes in her knee and not specifically related to the one time event that occurred on 9/1/04. He opined that the arthroscopy is indicated, but is secondary to the natural history and progressive degenerative changes of her patellofemoral joint and not causally related to the one time event that occurred while walking/running on 9/1/04.

Dr. Raab was of the opinion that petitioner has reached maximum medical improvement and was capable of returning to the workplace. He noted that petitioner is limited by her patellofemoral complaints. He recommended an FCE to get the specific parameters within which she could work. He opined that secondary to the degenerative changes in her patellofemoral joint, repetitive bending, stooping and squatting may be difficult for petitioner.

On 9/21/11 Dr. Bach drafted a letter to petitioner's attorney in response to his letter dated 8/25/11 and after reviewing the report of Dr. Raab. He agreed with Dr. Raab that petitioner has patellofemoral arthritis. He was of the opinion that petitioner had all the findings to perform the previous surgical procedure, a left knee arthroscopic lateral release and proximal tibial realignment osteotomy, and had done quite well with regard to her patellar instability complaints. However she continued to have anteromedial knee pain. Based on failed conservative measures including an injection, anti-inflammatory

medications, and physical therapy Dr. Bach recommended an arthroscopic evaluation. His goal for the procedure was to address any scar tissue within the knee, particularly the anteromedial aspect of the knee in the region of the medial plica area. His goal was not to debride any preexisting patellofemoral articular cartilage abnormalities. He was of the opinion that this surgery could be attributed to a causal relation in that it is to address scar tissue from the arthroscopic surgery with realignment to address her work relates injury. Dr. Bach was of the opinion that petitioner has significant patellofemoral chondromalacia which is in fact preexisting. With respect to her work injury, Dr. Bach was of the opinion that petitioner was capable of returning to work in a sedentary position with opportunities to frequently stand to stretch her knee. He recommended that she avoid activities where she squats, kneels, crawling or climbing ladders. He was of the opinion that more likely than not these restrictions will be permanent.

On 12/8/11 the deposition of Dr. Bach was taken on behalf of the respondent. Dr. Bach was of the opinion that Dr. Raab's recommendations were reasonable, but he did not agree with them. Dr. Bach was of the opinion that there is scarred soft tissue that exists in petitioner's knee, that if cleaned out is going to further help decompress the patellofemoral compartment and would significantly reduce her symptoms, but not cure what wear she has. He agreed that an FCE would be appropriate to objectively clarify what petitioner's capable of doing. He believed petitioner was capable of working a sedentary or slightly more than sedentary type of job demands. Dr. Bach opined that the injury was a contributing factor to her current condition of ill-being.

On cross-examination Dr. Bach was of the opinion that there is a possibility that petitioner's left knee complaints could be solely the result of the preexisting arthritis of the patellofemoral joint. Dr. Bach did not believe the MRI of October 2010 was the definitive answer on whether petitioner has scar tissue in her knee. Dr. Bach opined that if he went in and did not find any scar tissue he would not perform any other type of surgery. He stated that if there is no scar tissue then he would opine that that would indirectly conclude that her pain symptoms are coming from the wear.

On 2/15/12 petitioner filed a petition for Assessment of Penalties pursuant to Sections 19(k) and 19(l) of the Act, and attorneys' fees pursuant to Section 16 of the Act. Petitioner claims that she sustained an accident and respondent has refused to pay medical benefits and/or temporary total disability benefits contrary to its obligation under the Act. The petitioner further claimed that respondent's actions are considered to be in bad faith and fall within the meaning of Section 19(k); that respondent has failed to pay benefits to petitioner or provide a written explanation for the delay of over 14 days after the

demand, and respondent's actions fall within the provisions of Section 19(l); and, the respondent has been guilty of unreasonable and vexatious delay within the meaning of Section 16.

On 3/19/12 the evidence deposition of Dr. Raab was taken on behalf of the respondent. Dr. Raab opined that petitioner had Grade II and III chondromalacia of the patella when Dr. Mendel did the surgery on 12/14/04. He was of the opinion that that reflects a significant amount of wear, or degenerative arthritis. Dr. Raab did not think the procedure recommended by Dr. Bach would show any scar tissue. He was of the opinion that it would show more wear and tear under the kneecap, and progression of the chondromalacia of the patellofemoral joint. Dr. Raab believed the progression of the problem is going to continue with or without the knee arthroscopy. Dr. Raab opined that he believed petitioner may have aggravated her preexisting chondromalacia of her patella as a result of the injury on 9/1/04, however, in his opinion it was only a temporary aggravation of a preexisting problem that received appropriate and excellent treatment.

Petitioner testified that she continued in physical therapy until recently because she hoped there would be some good outcomes and knee strengthening. Petitioner testified that between the surgery in 1994 and the accident on 9/1/04 she had no problems. She testified that she coached girls softball, participated in town activities, bowled, walked 3 miles a day 4-5 days a week, gardened and rode a bike. She stated that she was active in everything she did and had no pain or discomfort.

Petitioner testified that her job as a secretary for respondent was not sedentary. She testified that in addition to her secretarial duties she helped teachers, the principal, the cooks, helped with playground activities, and whatever else was needed since it was a small school. Petitioner testified that in the summer she would go in to work periodically to look over shipments and go through them. She would then deliver them to the appropriate rooms. In July of 2004 she worked 71 hours, consisting of full days, during the registration period. She testified that these 103 hours are not classified as overtime.

Petitioner testified that she received TTD payments totaling $33,102.32. She testified that the rate would vary. She reported receiving three different rates, and then reported that there were periods when she did not receive some checks. Petitioner testified that she requested that the respondent make payments more promptly.

Petitioner testified that she still has pain in her knee, and she believes it is not near where it should or could be. She also reported that the strength is not there. Petitioner testified that she cannot bear full weight on her left knee. She also stated that when she walks down stairs periodically her knee is stiff and

cracks. She testified that she cannot squat. She reported a pulling sensation and pain on her kneecap when she squats. She reported aching and pain on the inside of her left knee when standing in excess of 30 minutes. Petitioner testified that she has prescription medications that she does not take because of the side effects. She testified that she takes Advil for her pain. Petitioner testified that she wants to undergo the recommended surgery.

Petitioner testified that while recovering from her work injury she worked as a receptionist for an optometrist. Her duties included greeting patients and getting files and updating files. She performed this job for three weeks in February of 2009. While performing these duties she noticed an onset of pain and discomfort when bending and squatting and getting up and down frequently. Petitioner testified that she has looked for work within her restrictions, but had not found any other work. She testified that she had applied for secretarial, receptionist, bank and other sedentary jobs but was never given an interview. She continues to look for work.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

Prior to the injury on 9/1/04 petitioner underwent two arthroscopic procedures on her left knee in 1991 and 1994. Petitioner testified that following her post-operative treatment after the surgery in 1994 she performed all her regular work duties, activities of daily living, and extracurricular activities without any problems until the accident on 9/1/04. Following the injury on 9/1/04 petitioner underwent conservative treatment that included injections, anti-inflammatories, and physical therapy.

On 11/24/04 Dr. Weiss, respondent's examining physician opined the arthroscopy surgery recommended by Dr. Mendel was related to the injury on 9/1/04, and that the injury on 9/1/04 caused a permanent aggravation of her preexisting condition. On 12/4/04 petitioner underwent a left knee arthroscopy with patellofemoral compartment chondroplasty. On 1/12/05 Dr. Mendel released petitioner to full duty and released her from his care.

On 6/27/05 petitioner returned to Dr. Mendel with complaints. Dr. Mendel was of the opinion that cause of these complaints was moderate wear on the undersurface of the patella. Petitioner was fitted with a brace and patellar tendon strap. She also underwent an injection.

On 11/18/05 petitioner returned to Dr. Mendel and reported about 50% improvement after the injection. Dr. Mendel recommended Hyalgen injections.

On 5/31/06 petitioner returned to Dr. Mendel with continued complaints of patellofemoral pain and discomfort that affected her daily activities. Dr. Mendel performed about 5 Hyalgen injections into

petitioner's left knee through 7/19/06. Once completed, petitioner was still having some difficulties with squatting and kneeling. Wear on the undersurface of the patella was still noted. On 8/30/06 Dr. Mendel noted that most of petitioner's symptoms were related to the patellofemoral joint. He assessed left knee residual patellofemoral pain secondary to wear.

On 4/18/07 petitioner still has complaints. Dr. Mendel recommended a patellofemoral replacement. Dr. Gause did not agree with this procedure. Dr. Mendel continued to treat petitioner conservatively.

On 5/14/08 petitioner was examined by Dr. Bach at the request of the respondent. He assessed recalcitrant patellar pain of the left knee status post arthroscopy. He also noted an increased Q-angle which was preexistent and which was a risk factor for patellofemoral symptoms. He opined that the treatment to date was reasonable. He recommended a Fulkerson anteromedialization proximal tibial osteotomy. Dr. Bach also opined a causal connection between petitioner's symptoms and the injury on 9/1/04. He opined that the chondromalacia of petitioner's patellofemoral compartment was most likely preexistent.

On 9/9/08 petitioner underwent a left knee arthroscopic lateral release and Fulkerson AMZ, proximal tibial osteotomy performed by Dr. Bach. Petitioner followed up post-operatively with Dr Bach. On 1/30/09 and 2/23/09 Dr. Bach released petitioner to return to work full duty without restrictions. Petitioner remained in physical therapy through April of 2009.

On 1/7/10 petitioner underwent a Section 12 examination by Dr. Zillmer at the request of the respondent. Dr. Zillmer opined that a causal relationship of the condition to petitioner's injury exists, and her work-related injury did permanently exacerbate a preexisting condition. Dr. Zillmer noted that because petitioner did not get back to pre-injury status, operative intervention was performed to improve her function and comfort.

On 6/14/10 petitioner followed-up with Dr. Bach for the first time since 4/6/09. Petitioner reported that she continued to have pain at times. Dr. Bach opined that petitioner's left knee was stable and the patella was stable. He was of the opinion that she likely suffered a flareup of patellofemoral pain. Dr. Bach resumed conservative treatment that included physical therapy and injections. On 10/12/10 Dr. Bach ordered an MRI of the left knee that he noted showed a small trochlear defect. Dr. Bach noted that the MRI showed no tear, and that petitioner's pain was likely due to some patellofemoral symptoms and possibly a medial plica. Petitioner continued undergoing conservative treatment.

On 3/21/11 Dr. Bach recommended a left knee arthroscopy to evaluate the patellofemoral compartment as well as excise the medial plica which appeared to be the source of petitioner's symptoms.

On 7/11/11 respondent had petitioner examined by a third Section 12 physician. Dr. Raab's impression was anterior knee pain, patellofemoral with associated patellofemoral chondrosis status post Fulkerson osteotomy. Dr. Raab was of the opinion that prior surgeries were for issues regarding the patellofemoral joint based on the operative reports, especially of the initial arthroscopic procedure subsequent to the reported work related injury of 9/1/04. Dr. Raab was further of the opinion that there is certainly a possibility that petitioner's work related injury may have aggravated her preexisting knee complaints, although the report of the injury was quite trivial. He opined that any further treatment would be attributed to the natural history and progressive degenerative changes of her patellofemoral joint and not causally related to the one-time event that occurred while walking/running on 9/1/04.

On 9/21/11 Dr. Bach drafted a letter to petitioner's attorney. Dr. Bach was of the opinion that petitioner has significant patellofemoral chondromalacia which is in fact preexisting. Dr. Bach was of the opinion that Dr. Raab's recommendations were reasonable, but he did not agree with them. Dr. Bach was of the opinion that there is scarred soft tissue that exists in petitioner's knee that if cleaned out is going to further help decompress the patellofemoral compartment and would significantly reduce her symptoms, but not cure what wear she has. Dr. Bach was of the opinion that there is a possibility that petitioner's left knee complaints could be solely the result of the preexisting arthritis of the patellofemoral joint. Dr. Bach did not believe the MRI of October 2010 was the definitive answer on whether petitioner has scar tissue in her knee. Dr. Bach opined that if he went in and did not find any scar tissue he would not perform any other type of surgery. He stated that if there is no scar tissue then he would opine that that would indirectly conclude that her pain symptoms are coming from the wear.

Based on the above, as well as the credible evidence, the arbitrator finds that it is unclear if petitioner's current condition of ill-being is causally related to the accident she sustained on 9/1/04. The arbitrator finds it unrebutted, based on the credible medical evidence that petitioner's current condition of ill-being as it relates to her left knee is causally connected to the accident she had on 9/1/04 through at least 1/7/10, the date Dr. Zillmer, respondent's examining physician, opined a causal relationship between petitioner's injury on 9/1/04 and her current condition of ill-being.

After that date even Dr. Bach, petitioner's treating physician, opined that he is not sure if petitioner's current condition of ill-being is causally related to the injury of 9/1/04. In his deposition on 12/8/11 Dr. Bach specifically opined that there is a possibility that petitioner's left knee complaints could

be solely the result of the preexisting arthritis of the patellofemoral joint. However, he indicated that the only way he would know if her current condition of ill-being is causally related to the injury on 9/1/04 or her preexisting condition was to perform the recommended arthroscopic surgery and if there was no scar tissue found he would opine that the petitioner's current complaints were coming from the natural wear of her patellofemoral joint. If in the alternative, scar tissue from the previous surgeries was found, a causal connection to the accident on 9/1/04 would exist.

Since the surgery that would determine what Dr. Bach's causal connection opinion would be has not yet occurred, the arbitrator finds the petitioner has not yet proven by a preponderance of the credible evidence that her current condition of ill-being after 1/7/10 is causally related to the accident of 9/1/04. This finding is not a determinative finding of whether or not petitioner's current condition of ill-being is causally related to the accident on 9/1/04. Should petitioner undergo the surgery recommended by Dr. Bach, the arbitrator would be open to readdressing the issue of causal connection as it pertains to the period after 1/7/10. However, at this point the arbitrator finds the petitioner has failed to prove by preponderance of the credible evidence that her current condition of ill-being after 1/7/10 is causally related to the accident on 9/1/04 and not her preexisting condition.

G. WHAT WERE PETITIONER'S EARNINGS?

Respondent offered into evidence petitioner's wage records from 9/1/03 through 9/1/04. Petitioner offered no objection to this evidence being offered. This evidence shows that from 9/1/03 through 9/1/04 petitioner worked 1744 hours at a rate of $8.67 per hour. Petitioner offered no credible evidence to support a finding that her overtime was regular and mandatory. In the 50 week period preceding the injury petitioner worked overtime in only 4 of the 25 pay periods.

Based on the above, the arbitrator finds the petitioner earned $15,120.48 in the 50 week period preceding the injury on 9/1/04, and earned an average weekly wage of $302.41.

J. WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?

The Arbitrator adopts her findings of fact and conclusions of law contained above with respect to the issue of causal connection and incorporates them herein by this reference.

Having found petitioner's current condition of ill-being through 1/7/10 causally related to the accident on 9/1/04, the arbitrator finds all treatment petitioner received from 9/1/04-1/7/10 was reasonable and necessary to cure or relieve petitioner from the effects of the injury she sustained on 9/1/04. The arbitrator bases this finding on the opinions of Dr. Bach, Dr. Mendel and Dr. Zillmer.

Following her Section 12 examination by Dr. Bach at the request of the respondent, petitioner started treating with Dr. Bach. On 9/8/08 Dr. Bach performed surgery on petitioner. In General Tire & Rubber Co. v Industrial Commission, 221 Ill.App.3d 641, 582 N.E.2d 744, 164 Ill.Dec. 181 (5th Dist. 1991) the appellate court held that expenses for travel to petitioner's own physician in excess of 100 miles each way were proper under Section 8(a) of the Act. The court found it was not unreasonable to travel for treatment by a specialist. However, the decision did not seem to infer that local treatment for travel would be included. The court based this finding on the concept that the employer must provide all necessary medical expenses that are reasonably required to cure or relieve the effect of the injury. The respondent offered no evidence to support a finding that the treatment recommended by Dr. Bach could be performed by any doctor in Albany, IL.

Petitioner presented unrebutted testimony that she lives in Albany, Il and travelled to Chicago, IL for the surgery by Dr. Bach on 9/9/08. The distance from Albany, IL to Rush Medical Center in Chicago, IL is 146 miles. The arbitrator finds it reasonable and necessary that petitioner would spend the night before and after the surgery in a hotel given the distance from Albany, IL to Chicago, IL. Petitioner's lodging costs for the two nights was $188.76. Petitioner is also entitled to mileage reimbursement for 292 miles associated with the surgery. She is also entitled to parking reimbursement of $5.00, and $10.80 in tolls from Albany, IL to Chicago, IL .

Petitioner also travelled for follow-up to Dr. Bach on 9/19/08, 10/6/08, 10/20/08, 12/1/08, 1/20/09, 2/23/09, and 4/6/09 before being released to full duty work and released from his care. After that date petitioner has failed to prove by the preponderance of the credible evidence that the treatment she needed could not have been provided by a doctor in her area. Based on the above, the arbitrator finds the petitioner is entitled to reimbursement for an additional 2,044 miles. She is also entitled to parking reimbursement of $49.00 for these dates, and $37.80 in tolls from Albany, IL to Chicago, IL.

The arbitrator finds the petitioner is not entitled to mileage reimbursement for physical therapy performed 17 miles away from her home.

On 1/7/10 petitioner was examined by Dr. Zillmer at the request of the respondent. Dr. Zillmer's office is located in Lemont, IL. The distance from Albany to Dr. Zillmer's office is 134 miles each way, or a total of 268 miles. Petitioner is also entitled to $4.30 in tolls. Respondent has already paid petitioner $150.00 for this examination.

Petitioner offered into evidence a receipt for $17.61 from Walgreens for gauze and knee wrap. This receipt is undated, and therefore not reimbursable. Petitioner offered into evidence a pharmacy receipt dated 9/09/08 in the amount of $17.77 for Hydrocodone.

Petitioner offered into evidence the bill from Advanced Physical Therapy for services after 3/3/11. Since these services are after the date through which the arbitrator has found the petitioner's condition of ill-being is causally related to her injury on 9/1/04, the arbitrator defers any finding on these bills from Advanced Physical Therapy.

Petitioner also offered into evidence a meal receipt for 7/11/11 in the amount of $5.52. This was the day she underwent the Section 12 examination by Dr. Raab, at the request of the respondent. Petitioner is entitled to reimbursement of this meal given the long distance to and from the exam.

Based on the above, the arbitrator finds the petitioner is entitled to the following payments pursuant to Section 8 and Section 8.2 of the Act:

- 9/8/08-9/10/08 – lodging in the amount of $188.76; mileage reimbursement for 292 miles at the prevailing mileage reimbursement rate as of that date; $5.00 for parking, and $10.80 for tolls.
- 6 follow-up visits with Dr. Bach on 9/19/08, 10/6/08, 10/20/08, 12/1/08, 1/20/09 - reimbursement for 1,752 miles at the prevailing mileage rate on these dates; parking reimbursement of $49.00 for these dates; and $37.80 in tolls from Albany, IL to Chicago, IL
- 1/6/10 Section 12 examination with Dr. Zillmer – 268 mileage reimbursement at the prevailing mileage rate for that date; and $4.30 in tolls. Respondent shall have credit for the $150.00 it has already paid petitioner.
- Pharmacy receipt dated 9/09/08 in the amount of $17.77 for Hydrocodone.
- $5.52 lunch bill on date petitioner underwent a Section 12 examination with Dr. Raab, at the request of the respondent.

K. IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE?

The Arbitrator adopts her findings of fact and conclusions of law contained above with respect to the issue of causal connection and incorporates them herein by this reference.

Dr. Bach, the doctor that has recommended an arthroscopic evaluation, could not opine that the recommended surgery is related to injury on 9/1/04. He opined that such a finding could not be made until after the surgery was completed and the findings were known. Dr. Bach opined that if scarred soft tissue exists in the petitioner's knee then the surgery is related to the injury on 9/1/04. He further opined that if no scar tissue is found within the knee, particularly the anteromedial aspect of the knee in the region of the medial plica area, then petitioner's pain symptoms are coming from the normal wear and tear on her knee and not the accident on 9/1/04.

Based on these opinions the arbitrator finds that at this point the petitioner has failed to prove by a preponderance of the credible evidence that the surgery recommended by Dr. Bach is causally related to the accident on 9/1/04. Dr. Bach could not opine at this time whether or not the surgery he has recommended is causally related to the accident on 9/1/04.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that the arthroscopic evaluation recommended by Dr. Bach is reasonable or necessary at this point to cure or relieve petitioner from the effects of the injury on 9/1/04. The petitioner's claim for prospective medical treatment is denied.

L. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

The Arbitrator adopts her findings of fact and conclusions of law contained above with respect to the issue of causal connection and incorporates them herein by this reference.

Petitioner alleges she was temporarily totally disabled from 12/14/04-1/25/05; 9/9/08-2/8/09, and 2/28/09-4/19/12. Respondent claims petitioner was not temporarily totally disabled after 1/30/09. Based on this stipulation, the arbitrator finds the period in dispute is only 1/31/09 through 8/7/12. For that reason the arbitrator will only address the period after 1/30/09.

On 1/30/09 and 2/23/09 Dr. Bach released petitioner to full duty work without restrictions. Following these releases petitioner worked for an optometrist from 2/9/09 through 2/27/09. On 4/6/09 Dr. Bach continued petitioner in physical therapy and released her from his care. He did not address her work status. However, on 9/9/09 Dr. Bach drafted a letter to petitioner's attorney stating that petitioner was working full duty without restrictions on 4/7/09 and could continue to do so.

On 6/14/10 when petitioner again started treating with Dr. Bach he did place her under restrictions. However, it is unclear whether or not petitioner's treatment after 1/17/10 is causally related to the

accident on 9/1/04 or her preexisting condition, and this finding cannot be determined until after petitioner undergoes the arthroscopic surgery recommended by Dr. Bach.

Based on the above, as well as the credible evidence the arbitrator finds the petitioner was temporarily totally disabled from 12/14/04-1/25/05, 9/9/08-1/30/09, a period of 26-5/7 weeks. The arbitrator finds the petitioner was not temporarily totally disabled from 1/31/09 through 6/13/10 based on Dr. Bach's full duty releases on 1/30/09 and 2/23/09, and Dr. Bach's opinion on 9/9/09 that petitioner was working full duty without restrictions on 4/7/09 and could continue to do so. Following her appointment with Dr. Bach on 4/6/09 petitioner did not follow up with Dr. Bach until 6/14/10. The arbitrator will defer any finding on petitioner's claim for temporary total disability benefits after 6/14/10 until after petitioner undergoes the arthroscopic surgery recommended by Dr. Bach and the findings and opinions related to that surgery are presented. Respondent shall be given credit for temporary total disability benefits already paid in the amount of $33,102.32.

M. SHOULD PENALTIES OR FEES BE IMPOSED UPON RESPONDENT?

The Arbitrator adopts her findings of fact and conclusions of law contained above with respect to the issue of causal connection and incorporates them herein by this reference.

The arbitrator finds a real controversy exists as to the issues herein. Therefore, the petitioner's claim for penalties and attorneys' fees is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lee Ammons,
Petitioner,

vs. NO: 12 WC 04568

Cook County,
Department of Corrections,
Respondent.

14IWCC0386

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary total disability, medical expenses, prospective medical expenses, and the nature and extent of Petitioner's disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 16, 2013 is hereby affirmed and adopted.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 27 2014

Daniel R. Donohoo

Charles J. DeVriendt

Ruth W. White

o-05/21/14
drd/wj
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

AMMONS, LEE
Employee/Petitioner

Case# **12WC004568**

COOK COUNTY DEPT OF CORRECTIONS
Employer/Respondent

14IWCC0386

On 5/16/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1315 DWORKIN AND MACIARIELLO
DAVID VanOVERLOOP
134 N LASALLE ST SUITE 1515
CHICAGO, IL 60602

0132 STATES ATTORNEY OF COOK COUNTY
JEREMY SCHWARTZ
500 RICHARD J DALEY CTR RM 509
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF **COOK**)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
X ☐ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Lee Ammons
Employee/Petitioner

v.

Cook County Department of Corrections
Employer/Respondent

Case # **12** WC **4568**

Consolidated cases:
~~14IWCC0386~~

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **4/26/13**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

14IWCC0386

FINDINGS

On **1/24/12**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

For the reasons stated in the attached conclusions of law, the Arbitrator finds that some of Petitioner's testimony was not credible and that Petitioner failed to establish causation as to his claimed current cervical and lumbar spine conditions of ill-being as well as to his treatment and claimed lost time.

In the year preceding the injury, Petitioner earned $**53,661.92**; the average weekly wage was $**1,031.96**.

On the date of accident, Petitioner was **56** years of age, ***single*** with **0** dependent children.

Respondent shall be given a credit of $ for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $.

Respondent is entitled to a credit of $ under Section 8(j) of the Act.

ORDER

FOR THE REASONS STATED IN THE ATTACHED CONCLUSIONS OF LAW, THE ARBITRATOR FINDS THAT SOME OF PETITIONER'S TESTIMONY WAS NOT CREDIBLE AND THAT PETITIONER FAILED TO ESTABLISH CAUSATION AS TO HIS CLAIMED CURRENT CERVICAL AND LUMBAR SPINE CONDITIONS OF ILL-BEING AS WELL AS TO HIS TREATMENT AND CLAIMED LOST TIME. COMPENSATION IS DENIED.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Molly C Mason
Signature of Arbitrator

5/16/13
Date

MAY 16 2013

Lee Ammons v. Cook County Department of Corrections
12 WC 4568

Arbitrator's Findings of Fact

Petitioner testified he has worked as a correctional officer for Respondent since June of 1990. His job involves supervising inmates at Respondent's facility.

On direct examination, Petitioner testified he felt "fine" when he arrived at work on the morning of January 24, 2012. He denied having any tailbone pain when he arrived. At some point that day, he and two co-workers were working in a security office known as the "bubble." The office was about 20 feet by 20 feet in size. Petitioner testified that, immediately before the accident, he was sitting in a chair near a large "I.D." board. The board contained about fifty slots, with each slot containing an inmate's I.D. card. The board allowed Respondent to keep track of the inmates' whereabouts. The telephone rang. One of the two co-workers picked up the telephone. The incoming call had to do an inmate who was going to be leaving the facility. Since Petitioner was near the board, he reached over to remove the inmate's I.D. card. Petitioner testified he attempted to retrieve the card by putting his right arm across his chest and leaning forward, to his left, and down. The card was at a lower level on the board. As Petitioner did this, the chair in which he was sitting "flipped backward," causing Petitioner to fall, striking his tailbone on the concrete floor. When the chair landed, it struck the back of Petitioner's neck.

Petitioner testified he initially felt embarrassed and stunned. He noticed some pain in his tailbone. Later, he began to experience neck pain and "clicking" in his right ear. He notified his supervisor, Sergeant Brazelton, of the accident [notice is not in dispute], left Respondent's facility and went to Cermak Hospital. [The Cermak Hospital records are not in evidence.]

Petitioner retained counsel the day the accident occurred. Arb Exh 2.

On January 26, 2012, Petitioner went to Dr. Ogurkiewicz at Midwest Therapy Center. Petitioner acknowledged having previously undergone therapy at this facility. A "registration sheet" in the doctor's chart reflects that Petitioner injured his lower back, tailbone, shoulders and knees at work on January 24, 2012. The mechanism of injury is not described. The "registration sheet" also reflects that Petitioner sought Emergency Room care at Cermak Hospital after the injury. It also reflects that Petitioner injured his lower back in the past and did not fully recover from that injury. The sheet appears to bear Petitioner's signature and the date "1/26/12." PX 2. RX 2, A2.

Dr. Ogurkiewicz's typed note of January 26, 2012 reflects that Petitioner complained of pain in his neck, back, shoulders and knees. The note contains no mention of a work accident. The doctor described Petitioner's past history as "unremarkable for involved areas." The doctor examined Petitioner and diagnosed acute sprains/strains to the cervical spine, lumbar

spine and shoulders. The doctor also noted a left patella contusion and a right patella abrasion. He took Petitioner off work. PX 2. RX 2, p. A24.

On January 30, 2012, Petitioner underwent a cervical spine MRI at Southwest Hospitals MRI Center. The MRI report identifies Dr. Kelsey as the prescribing physician but there is no indication that Dr. Kelsey prescribed this MRI secondary to the claimed work accident. The MRI revealed multi-level degenerative changes with the most significant findings at C5-C6 and C6-C7. PX 1.

Petitioner returned to Dr. Ogurkiewicz for massage therapy on numerous occasions thereafter, through June 26, 2012, with the doctor continuing to keep him off work until April 10, 2012, at which point he indicated Petitioner was returning to work "due to financial hardship against medical advice." RX 2, p. A9.

On February 2, 2012, Petitioner saw Carla Bragg, a certified medical assistant working under Dr. Kelsey's supervision at Advocate Medical Group. The note of February 2, 2012 is labeled "PCP Chronic Care Note." Bragg's history reflects that Petitioner "fell on 1/24/12 at the job when the chair fell out from under him at the job." Bragg indicated that Petitioner struck his tailbone and that the "chair back lodged behind [Petitioner's] neck." Bragg noted that Petitioner initially underwent treatment at Cermak Health Services and had started a course of therapy. Bragg described Petitioner as 6 feet tall and weighing 341 pounds. She noted no abnormalities on examination. She described Petitioner's neck pain as "worse after accident 1/24/12, now with radiculopathy down right arm." She noted the MRI results. She indicated Petitioner planned to see an orthopedic surgeon.

Petitioner saw Dr. Schiappa, an orthopedic surgeon, on February 7, 2012. The doctor's handwritten note of that date is very difficult to read. It appears that he prescribed a cervical collar. PX 3.

Petitioner returned to Dr. Schiappa on February 13, 2012. The doctor's typed history sets forth the following history:

> "Apparently, the patient states he had been injured in an accident while at work on 1/24/12, when the patient fell off the chair. Apparently, the chair broke under him while sitting in it and sustained injury to his cervical lumbar spine."

On examination, Dr. Schiappa noted positive straight leg raising at 90 degrees and a limited range of cervical spine motion. He provided a cervical collar and recommended that Petitioner stay off work and continue therapy. PX 3. RX 3, p. 13.

Petitioner next saw Dr. Schiappa on February 21, 2012, with the doctor noting that Petitioner was continuing to undergo therapy. The doctor prescribed Naprosyn and instructed Petitioner to continue therapy. He released Petitioner to unrestricted duty as of February 23,

2012, noting that Petitioner was returning to work against his advice due to financial difficulties. RX 3, p. W4-W6. Petitioner returned to Dr. Schiappa on March 6, 2012. The doctor's brief handwritten note of that date is virtually impossible to read. PX 3, RX 4, p. W3.

On March 7, 2012, Petitioner saw another certified medical assistant, Kelly Lewis, at Advocate Medical Group. Lewis described Petitioner as "here for paperwork for his neck injury to be completed." She also noted that Petitioner complained of neck soreness and right hand numbness. She prescribed Tramadol and noted that Dr. Schiappa could be "on the case" since the case involved "work comp." On examination, she noted pain on range of cervical spine motion. She described Petitioner's back as "normal." She indicated Petitioner needed to see an orthopedic surgeon to evaluate a cyst shown on a recent MRI of the spine. RX 3, pp. 9-12.

Petitioner testified that he was taken off work again as of March 9, 2012 due to pain. At that point, he was experiencing pain in his low back and the right side of his neck. Dr. Ogurkiewicz's records reflect that he took Petitioner off work on March 9, 2012 due to "acute cervical and lumbosacral strain/spasm." RX 2, p. A6.

Petitioner testified he resumed working on April 10, 2012. As noted previously, Dr. Ogurkiewicz released Petitioner to full duty as of that date, indicating Petitioner was returning to work for financial reasons and against his advice.

On September 24, 2012, Petitioner returned to Advocate Health Centers. It appears he saw both Dr. Kelsey and the doctor's assistant, Kelly Lewis, CMA, on this date. The history states, in part:

> "He has a case with workman's comp for his neck and he wanted me to write that he will have problems with his neck for a long time. His other doctors (Dr. Orkiewicz [sic] and Dr. Schiappa) both say he will have problems with his neck according to Mr. Ammons so I quoted them in my note."

The examination findings reflect that Petitioner's neck and back were "normal." Another note states: "he is back to work now and neck seems better but ultimate prognosis will be with ortho." RX 3, pp. 5-8. There is no evidence indicating that Petitioner returned to Dr. Schiappa or saw a different "ortho" after September 24, 2012.

A subsequent Advocate Health Center note, dated November 5, 2012, describes Petitioner as having "stable neck and low back pain." RX 3, pp. 1-4.

Petitioner testified he received no temporary total disability benefits in connection with this claim.

Petitioner testified he feels about "85% good" now. He continues to experience low back pain and spasms. These symptoms increase in cool, rainy weather. If he turns his head rapidly, he sometimes feels neck pain.

Under cross-examination, Petitioner acknowledged pursuing quite a few other workers' compensation claims in the past. One of these prior claims involved a chair. He was diagnosed with degenerative disc disease before his claimed accident of January 24, 2012. He is still performing full duty for Respondent. The chair he was sitting in immediately prior to the accident of January 24, 2012 did not have wheels. He does not know whether the chair broke. He was not aware of anyone having inspected the chair after the accident. After the chair flipped, the chair flew high up in the air. When the chair came down, it "caught" his neck.

On redirect, Petitioner testified he is not sure when he was diagnosed with degenerative disc disease. He saw a doctor for this condition before January 24, 2012. As of about three weeks before January 24, 2012, he was undergoing therapy three or four times a week due to back spasms that would cause him to wake at night. As of January 24, 2012 he was no longer experiencing these spasms.

In addition to the exhibits previously discussed, Petitioner offered into evidence unpaid bills from Midwest Physical Therapy (Dr. Ogurkiewicz) and Dr. Schiappa. The parties stipulated that the Advocate Medical Group bill was paid. Arb Exh 1.

No witnesses testified on behalf of Respondent. Respondent offered into evidence a "Cook County Department of Corrections Memorandum" dated January 25, 2012, authored by an individual named S. Hensley. RX 6. The memorandum states: "I pulled the chair and found nothing broken/cracked. It works fine. Lee Ammons has a history of claims. Need to review!" Petitioner did not object to RX 6.

Respondent also offered into evidence records concerning pre-accident treatment (RX 5) and a report concerning Dr. Julie Wehner's Section 12 examination of January 18, 2013 (RX 1). The doctor's history reflects that, on January 24, 2012, Petitioner was "stretching to get a badge off a board when the chair came out from underneath him and caused him to fall and injured his neck, right knee and low back." The history also reflects that the chair landed on Petitioner's right shoulder and neck.

Dr. Wehner noted that Petitioner complained of pain in the right side of his neck, his low back and his right knee. She also noted that Petitioner "has at least 2-3 prior work-related injuries" and "would receive heat for his low back in the past."

Dr. Wehner reviewed a number of treatment records dating back to 2000. [These records are in RX 4. They include a Section 12 examination report dated June 9, 2005 reflecting that Petitioner underwent cervical and lumbar spine MRIs in 2005 in connection with a work accident of May 3, 2005. RX 4, pp. A81-85.] Dr. Wehner also reviewed summaries of eleven prior workers' compensation claims. Based on this review, she stated:

> "[Petitioner] is now complaining of neck, bilateral shoulder pain, low back pain and knee pain. All of these previous areas have been documented as problematic for him."

Dr. Wehner indicated she reviewed the report concerning the January 30, 2012 cervical spine MRI. She described the MRI findings as "consistent with degenerative changes." She found "no specific acute injury other than some subjective complaints of pain which have been present throughout many years." She found no need for any specific additional treatment. She indicated "the diagnosis would be some soft tissue sprains or contusions." She opined that these soft tissue injuries did not give rise to the need for chiropractic care or time off of work. She found Petitioner capable of full duty. She addressed permanency as follows:

> "Based on the AMA Guidelines for Disability Rating, he falls into the category of a lumbar spine strain with no significant clinical findings and the impairment rating would be zero."

RX 1.

Arbitrator's Credibility Assessment

Petitioner's testimony that he felt "fine" when he arrived at work on January 24, 2012 is questionable, given his history of back and neck complaints and his admission that he was undergoing therapy three or four times per week for back spasms as recently as three weeks before January 24, 2012.

Petitioner had a tendency to exaggerate. He testified that the chair "flew to the top" at the time of the accident. When he testified to this, he pointed to the ceiling of the Arbitrator's hearing room.

Petitioner testified that, after the chair flipped over, he fell to the concrete floor, landing on his tailbone. This described mechanism of injury is not consistent with the bilateral patellar abrasions/contusions Dr. Ogurkiewicz documented on January 26, 2012.

Did Petitioner sustain an accident on January 24, 2012 arising out of and in the course of his employment?

For an injury to be compensable, it must "arise out of" and "in the course of" one's employment. 820 ILCS 305/2. The phrase "in the course of" refers to the time, place and circumstances under which the accident occurred. The Arbitrator finds that Petitioner's accident of January 24, 2012 occurred in the course of his employment. Petitioner testified the accident occurred on Respondent's premises during his work shift. The "arising out of" prong

requires an injury's origin to be in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the injury. Nabisco Brands, Inc. v. Industrial Commission, 266 Ill.App.3d 1103, 1106 (1994). "Typically, an injury arises out of one's employment if, at the time of the occurrence, the employee was performing acts he was instructed to perform by the employer, acts which he or she had a common law or statutory duty to perform or acts which the employee might reasonably be expected to perform incident to his or her assigned duties," 266 Ill.App.3d at 1106. The Arbitrator finds that Petitioner's accident of January 24, 2012 arose out of his employment. Petitioner is a correctional officer whose job requires him to keep track of inmates at Respondent's facility. No one contradicted Petitioner's testimony concerning the underlying purpose of the inmate I.D. card board. Nor did anyone contradict Petitioner's testimony that he was reaching and leaning to remove an inmate's I.D. card from the lower portion of this board when the chair in which he was sitting "flipped backward," causing him to fall to the concrete floor. There is no indication that Petitioner was misusing the chair when this occurred. While there is no evidence indicating the chair broke, it is evident the chair either did not properly accommodate a person of Petitioner's size and/or did not function as anticipated.

Respondent cites Board of Trustees of University of Illinois v. Industrial Commission, 44 Ill.2d 207 (1969) in support of its argument that the accident did not arise out of Petitioner's employment. The Arbitrator views Board of Trustees as factually distinguishable from the instant case. In Board of Trustees, a teaching assistant was sitting at his desk when he heard a noise. He turned in his chair and felt his back "snap." Petitioner, in contrast, was performing a work-related task at the time of his injury.

Did Petitioner establish a causal connection between the accident of January 24, 2012 and his claimed current lower back and neck conditions of ill-being?

The Arbitrator finds that Petitioner failed to establish a causal connection between his January 24, 2012 accident and his claimed current lower back and neck conditions of ill-being.

There are some obvious gaps in the information available to the Arbitrator. On direct examination, Petitioner testified he felt "fine" and had no tailbone pain when he arrived at work on January 24, 2012. On redirect, Petitioner admitted he was undergoing therapy for back spasms three to four times weekly three weeks before that date. He denied that he was still experiencing spasms as of January 24, 2012. The Arbitrator finds this denial not credible. The records concerning the pre-accident therapy are not in evidence. When Petitioner saw Dr. Ogurkiewicz on January 26, 2012, he completed a form indicating he had not yet recovered from a previous lower back injury. PX 2. Petitioner testified he underwent emergency treatment at Cermak Hospital on the day of the accident. The hospital records are not in evidence. At Dr. Kelsey's direction, Petitioner underwent a cervical spine MRI on January 30, 2012, six days after the accident. The record does not contain any note indicating why or when Dr. Kelsey prescribed this MRI. The first note in evidence authored by Dr. Kelsey is a "PCP Chronic Care Note" dated February 2, 2012. PX 1. RX 3, pp. 14-17. The Arbitrator cannot assume that Dr. Kelsey prescribed the MRI in connection with the January 24, 2012 accident.

The report concerning the MRI reflects that the scan was being performed due to "cervical spine impingement." The MRI did not reveal any acute abnormalities.

While Petitioner's treating physicians made note of the accident, they did not specifically comment on causation or aggravation. The only specific causation opinion in evidence is Dr. Wehner's opinion that the accident resulted in "some soft tissue sprains or contusions" that did not warrant chiropractic care or time off from work. RX 1.

The Arbitrator finds that Petitioner failed to meet his burden of proving that the accident of January 24, 2012 caused, or contributed to, his claimed current cervical and lumbar spine conditions of ill-being. The Arbitrator further finds that Petitioner failed to establish causation as to the treatment he underwent with Drs. Ogurkiewicz, Kelsey and Schiappa and his claimed lost time and permanency. Compensation is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Robert Helmboldt,
Petitioner,

vs. NO: 12 WC 37216

Senior Lifestyle Corporation,
Respondent.

14IWCC0387

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident and temporary total disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 10, 2013 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 27 2014

Daniel R. Donohoo

o-05/21/14
drd/wj
68

Charles J. DeVriendt

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) DECISION OF ARBITRATOR

HELMBOLDT, ROBERT
Employee/Petitioner

Case# **12WC037216**

SENIOR LIFESTYLE CORP
Employer/Respondent

14IWCC0387

On 7/10/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

2356 FOHRMAN, DONALD W & ASSOC
ADAM J SCHOLL
101 W GRAND AVE SUITE 500
CHICAGO, IL 60610

1109 GAROFALO SCHREIBER HART ET AL
ANDREW RANE
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Robert Hemboldt
Employee/Petitioner

v.

Senior Lifestyle Corp.
Employer/Respondent

Case # **12** WC **37216**

Consolidated cases: **N/A**

14IWCC0387

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Barbara N. Flores**, Arbitrator of the Commission, in the city of **Chicago**, on **May 16, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other

FINDINGS

On the date of accident, **October 4, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did not* sustain an accident that arose out of and in the course of employment as explained *infra*.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is not* causally related to the accident as explained *infra*.

In the year preceding the injury, Petitioner earned **$61,897.97**; the average weekly wage was **$1,190.35**.

On the date of accident, Petitioner was **53** years of age, *married* with **no** dependent children.

Respondent *has* paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$1,587.14** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$1,587.14**.

Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner failed to establish that a compensable accident arose out of and in the course of his employment as claimed. By extension, all requested compensation and benefits are denied.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

July 9, 2013
Date

JUL 10 2013

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*
19(b)

Robert Hemboldt
Employee/Petitioner

v.

Senior Lifestyle Corp.
Employer/Respondent

Case # **12** WC **37216**

Consolidated cases: **N/A**

14IWCC0387

FINDINGS OF FACT

The issues in dispute include accident, causal connection, and a period of temporary total disability commencing on October 10, 2012 through May 16, 2013. Arbitrator's Exhibit ("AX") 1. The parties have stipulated to all other issues or indicated their agreement to reserve their respective rights to dispute certain other issues after resolution of the issues of accident and causal connection. AX1; May 16, 2013 Arbitration Hearing Transcript.

Background

Petitioner testified that he was employed by Respondent as the director of plant operations on October 4, 2012 and had been so employed for two years and seven months, to the day. Petitioner testified that Respondent operated an assisted and independent living retirement community.

Petitioner testified that his responsibilities included acting as the head of housekeeping, maintenance, and laundry. He also testified that he procured various contracts for the buildings, held safety meetings, and performed a number of glorified maintenance tasks. His physical tasks included one hour of daily paperwork, daily stand up meetings with the department heads, ensuring that main tasks were done, and working with residents (i.e., swimming with residents two days per week, responding to miscellaneous household maintenance requests from residents). To perform certain physical tasks, Petitioner used hand tools ranging from a saw to a plunger. Petitioner is right hand dominant. He testified that he had to do everything with two hands including taking out the garbage, plumbing with a wrench, fixing/washing windows, etc.

Petitioner testified that he was a general contractor for 30 years and a carpenter by trade before becoming employed with Respondent. He testified that he always did side work while working for Respondent including building decks, basement remodeling, hanging drywall, and kitchen/bathroom remodeling. For example, the week before his claimed injury, Petitioner testified that he worked for Valspar Corporation installing drywall on a ceiling in their office on September 27 and 28, 2012 in the evening. He testified that he used his right arm for this job to hang drywall, insert screws, and reach overhead. He testified that he had no complaints of pain or symptoms at that time.

Petitioner further testified that he had no problems or symptoms in the right arm before the claimed date of accident other than "getting older" body aches. Petitioner testified that he noted no pain in shoulder before the claimed date of accident and that he had no medical treatment within two years of October 4, 2012. The medical records reflect that Petitioner's medical history was significant for a right rotator cuff repair in 1997 and reported right shoulder pain over one year prior to August 29, 2008 worsened with sleeping. RX1 at 24-26.

On cross examination Petitioner acknowledged that on August 29, 2008 Dr. Ahmad diagnosed him with probable right shoulder impingement and referred him to an orthopedic physician if his symptoms persisted noting that he may need an MRI. *Id.* The Arbitrator notes her observation that Petitioner seemed confused during his testimony on cross examination when confronted with the August 29, 2008 record and that he slowly iterated "ddx" or "sx" or "f.u." suggesting that he did not understand the medical shorthand contained therein. In contrast, Petitioner appeared to understand it immediately and without prompting on re-direct examination questioning from his attorney.

Petitioner also maintained, on cross examination, that he had no problems with his shoulder prior to the claimed date of accident and testified that he did not recall going in for shoulder treatment on August 3, 2010. When presented with a medical record of the same date, Petitioner testified that he saw a doctor in August of 2010 for rotator cuff pain and that he recalled walking out. *See* RX1 at 31. The medical records reflect that Petitioner arrived at 9:17 a.m. and "ROTATOR CUFF PAIN/NEW INS CIGNA / CLS/patient walked out at 9:58a, had been waiting for half hour...." *Id.* Petitioner testified that he was already working for Respondent at this time, but without any shoulder problems or accident occurring in 2010, and that he could not recall what he did to his shoulder prompting the visit.

On re-direct examination questioning, Petitioner testified that he did not see a doctor on this date, that he did not follow up with any doctor thereafter, and that, other than these two visits, he had no other right shoulder symptoms.

Accident

On October 4, 2012, a Thursday, Petitioner testified that he was in Fort Wayne, Indiana at the request of the regional director of operations who asked him to go there to ensure the facility met state regulations. Petitioner believed that his counterpart at that facility was terminated some weeks earlier.

Petitioner testified that he arrived late on Monday or early on Tuesday and met with the executive director, Sally Sharp ("Ms. Sharp"), on Tuesday. They toured the facility. Petitioner testified that he wrote a list and she asked him to perform various job duties off top of her head including repairing a skylight, drywall and ceiling area that had water damage. Petitioner testified that the skylight was 10-11' up running on the slope of the roof requiring him to elevate himself. He used a 6' ladder and his right arm to patch all the overhead work on October 3, 2012.

Also on October 3, 2012, Petitioner testified that the executive director of his facility and his boss, Ryan Carney ("Mr. Carney"), asked him to come back to Barrington. Petitioner testified that he could not recall the reason for Mr. Carney's request.

On October 4, 2012, Petitioner testified that he returned to sand the skylight. He testified that he put the ladder up and sanded certain areas smooth with his right arm. He also testified that he was improperly standing on and facing outward on the ladder and reaching over a wall that separated the two rooms that the skylight covered; as he was trying to reach too far, his heel slipped off the ladder and he fell down landing on his feet. He testified that he hurt his right shoulder by reaching across the wall and, as he slid, his arm caught the wall on the way down. On re-direct examination questioning, Petitioner testified that his right arm/elbow was hooked over the wall (an 8' high partition that did not go all the way up to the ceiling) over which he was reaching.

On cross examination, Petitioner testified that he dropped the sanding sponge when he fell, he did not yell out when his arm struck the wall, he did not know if there were any witnesses to the incident, he did not seek anyone out after the accident, he did not give notice to Ms. Sharp because she was not there that day, and he did not seek out any first aid or nursing care. Petitioner added that he did not see any of Respondent's staff at the time.

Petitioner testified that he moved the ladder to the other side and sanded the remaining area with his left arm because his right arm kind of stung. Petitioner added that the remaining task only took a couple of minutes after which he folded and took the ladder back to the closet. On cross examination, Petitioner testified that he dropped the sanding sponge when he fell and, after the incident, collected the drop cloth and disposed of it in a garbage can and placed the ladder in a closet. Petitioner further acknowledged that his last act of employment for Respondent was performing the duties that lead to this alleged and un-witnessed injury.

Petitioner testified that then he left Ft. Wayne to return to Barrington that day around 11:00 a.m. eastern standard time. He testified that he drove back to Barrington and that his right arm was a little sore. He testified that he had taken some naproxen 500 mg and that the drive from Ft. Wayne to Barrington was approximately 2:45 to 3 hours long because his brakes were failing and he stopped to drop off his truck with his nephew at a nearby car dealership and used another car to drive the remaining four miles to work. He testified that he did not notice anything in particular when he arrived at the Barrington facility.

On cross examination, Petitioner also acknowledged that he drove approximately 200 miles from the Indiana facility to a Ford dealership and then to his home office at Respondent's Barrington facility. He added that, on long trips, he drives with his left knee and that he had a cell phone, but he could not recall contacting anyone about his shoulder during the three hour drive back to Barrington. Petitioner also could not recall any bruising, stiffening or swelling in the right arm despite acknowledging a diagnosis of a traumatically torn rotator cuff.

When Petitioner finally arrived at Respondent's Barrington facility, he testified that he met with Mr. Carney and Janet Stender ("Ms. Stender"). Petitioner testified that he did not know what the meeting was about, but that Mr. Carney informed him that someone had raised an issue about his hiring practices and that he was going to be placed on suspension. Petitioner testified that he did not report what happened in Ft. Wayne at this meeting because he did not think anything of it; his pain seemed to have subsided.

Petitioner also testified that he then went to get paperwork that would have exonerated him of the charges regarding his suspension from his truck [at the Ford dealership] and drove back to the Barrington facility. He testified that he told Mr. Carney that the paperwork showed something that would exonerate him of the charges. Petitioner testified that this exchange lasted approximately two minutes. Petitioner did not mention his shoulder injury at this time either.

Petitioner acknowledged receipt of a company handbook with which he testified that he was not entirely familiar. *See* RX3. Specifically, Petitioner testified that he was not familiar with the sections regarding injuries and illnesses. Petitioner acknowledged that the handbook and company policy required him to immediately report any injury, no matter how slight, to his supervisor. Petitioner also acknowledged that he had previously completed an incident report on the same date of an accident at work on July 20, 2010. *See* RX4. On re-direct examination, Petitioner added that he had other slight injuries in the past that he did not report (e.g., slipping on ice one day, being stuck with a needle, falling while getting out of truck and twisting his ankle) and over which he did not file any workers' compensation claims, but he acknowledged that none of these injuries required surgery.

On Friday October 5, 2012, Petitioner testified that he was still stiff. He testified that he and his wife drove six hours to his daughter's university in northern Michigan for parents' day. Petitioner testified that he drove and noticed more pain if he kept his arm still. He testified that they went to a football game, did some walking around the campus, and that he took some pain pills, but received no medical treatment. Petitioner testified that they returned home on Sunday at noon, that he did not sleep well on Sunday night, and that the right shoulder pain worsened by Monday. On cross examination Petitioner testified that he was scheduled for the aforementioned trip to his daughter's college; he denied any plan to play golf or actually playing golf that weekend. He added that he does not regularly play golf.

Petitioner testified that he thought that the pain would go away, but on Tuesday morning his wife told him to go to see a doctor. Petitioner testified that he went to the doctor's office where he always sends his employees; Alpine Family Physicians.

On October 9, 2012 at 3:38 PM, Petitioner sent an e-mail to Mr. Carney stating "Ryan, I apologize but I will not be back today, I have a family emergency. I will bring in the letter tomorrow. Bob[.]" RX5. Petitioner provided no further information in this email.

Petitioner testified that he did not report the alleged injury on October 5, 2012 or at any time until October 10, 2012 when he reported the alleged accident at work to his physician at Alpine Family Physicians.

Medical Treatment

The following day, October 10, 2012, Petitioner went to Alpine Family Physicians in Lake Zurich and was examined by a certified physician's assistant, Ms. Kelly. RX2 at 5-10. Petitioner reported right shoulder pain and injury six days prior while on the ladder fixing a skylight, falling off, and catching his shoulder. *Id.* He also reported pain with movement, throbbing, difficulty sleeping due to pain, trouble extending his arm, a shooting pain into the forearm, and use of advil without relief. *Id.* Petitioner further reported that a "similar injury occurred a few years ago." *Id.* Petitioner underwent x-rays which revealed mild irregularity of the inferior glenoid which may represent a nondisplaced fracture, no definite osseous abnormalities, a properly located glenohumeral joint, and degenerative changes. *Id.* Ms. Kelly diagnosed Petitioner with a right shoulder injury, prescribed hydrocodone and nabumetone, recommended a shoulder sling, placed Petitioner off work, and recommended physical therapy once his pain improved. *Id.* Petitioner testified that he sent an email and scanned a letter from Ms. Kelly to Mr. Carney.

On October 16, 2012, Petitioner saw Dr. Cummins at Lake Cook Orthopedics. PX2 at 7-9; RX2 at 3-4. Petitioner reported an accident at work on October 4, 2012 when he fell approximately 6 feet down off a ladder while sanding a skylight and that his arm was forced up away from his body and experiencing fairly severe pain. *Id.* He also reported pain at a level of 7-8/10, taking Norco and ibuprofen which did a poor job of controlling his pain, inability to sleep on the right side or reach a high shelf, and having a very difficult time managing toileting or washing his back. *Id.* On examination of the right shoulder, Petitioner exhibited quite a bit of guarding, ability to elevate to about 110° with encouragement and slightly more passively, weakness on abduction and external rotation, and guarding with a small amount of crepitation. *Id.* Dr. Cummins diagnosed Petitioner with a right shoulder strain with the possibility of a nondisplaced glenoid fracture or rotator cuff tear. *Id.* He prescribed narcotic pain medication, ordered an MRI, continued Petitioner's sling immobilization, and kept Petitioner off work. *Id*; *cf.* PX2 at 43 (Petitioner is not placed off work, but restricted to no use of the right arm and no driving or operating machinery).

On October 17, 2012, Petitioner underwent the recommended right shoulder MRI without contrast. PX1. The interpreting radiologist noted the following: (1) severe hypertrophic degenerative change of the acromioclavicular ("AC") joint with inferior osteophytes formation of the distal clavicle effacing the myotendinous junction of the supraspinatus; (2) bone marrow edema surrounding the AC joint; (3) a postoperative type change of the lateral aspect of the distal acromion, a complete tear of the supraspinatus tendon at the distal insertion site measuring 1.5 cm transverse by .6 cm superior to inferior by 1.6 cm in the anterior to posterior; (4) severe diffuse rotator cuff tendinosis and thickening; (5) moderate atrophy of the supraspinatus muscle; (6) mild atrophy of the teres minor muscle; (7) mild diffuse chondromalacia with a moderate joint effusion; (8) blunting and irregularity anterior glenoid labrum suggestive of chronic repetitive trauma; (9) blunting of the bicipital labral complex with findings suspicious for a tear of the long head of the biceps tendon with inferior retraction to the level of the proximal humeral diaphysis; and (10) fluid in the subacromial/subdeltoid bursa. *Id.*

At trial, Petitioner testified that he was terminated by Respondent effective October 24, 2012. To Petitioner's knowledge, his suspension was never lifted. Petitioner testified that he has not worked in any capacity since the incident on October 4, 2012.

On October 26, 2012, Petitioner returned to Dr. Cummins reporting somewhat worsened pain and continued symptomatology. PX2 at 10-12, 44. Dr. Cummins reviewed Petitioner's MRI and noted degenerative changes of the AC joint and Petitioner's lack of symptomatology at that site. *Id.* He also noted a 1.5 cm tear involving the supraspinatus tendon, diffuse rotator cuff tendinopathy with mild atrophy of the supraspinatus muscle and the teres minor, fluid in the subacromial space, mild chondromalacia of the glenohumeral joint, no definitive evidence of a labral tear, and a subluxed biceps compared to the radiologist's impression of the biceps tear. *Id.* Dr. Cummins diagnosed Petitioner with a right shoulder rotator cuff tear with possible biceps subluxation or biceps tear. *Id.* He recommended right shoulder arthroscopic acromioplasty, rotator cuff repair, and probable open biceps tenodesis. *Id.* Dr. Cummins refilled Petitioner's prescriptions and kept him off work until the time of surgery. *Id.*

Record Review – Dr. Cole

On November 14, 2012, Dr. Cole performed a record review at Respondent's request. RX2. Dr. Cole noted the reported mechanism of injury to be that Petitioner was sanding an area and standing up four rungs high on a ladder over an 8 foot wall with no ceiling when his foot slipped causing him to drop to the ground landing on his feet with his right arm simply over his head. *Id.* Dr. Cole also noted Petitioner "states that after he fell he was able to move the ladder to the other side of the wall and to finish his overhead sanding. He did not report it to his employer right away, but rather the next week." *Id.* Dr. Cole reviewed an injury report dated October 15, 2012 and Petitioner's October of 2012 treating medical records. *Id.*

Dr. Cole diagnosed Petitioner with a chronic right shoulder rotator cuff tear which he did not believe resulted from Petitioner's work based on the magnitude of the tear suggesting a large, possibly chronic tear that, if it had occurred on Petitioner's claimed date of accident, he would have been unable to continue working as he reported. *Id.* Additionally, Dr. Cole noted that if Petitioner had indeed played golf the same weekend, it was something that might or could have easily aggravated a pre-existing tear. *Id.* Notwithstanding, Dr. Cole noted that if Petitioner truly aggravated his right shoulder and "had severe pain it would be very unlikely that he would continue to work that same day with any overhead activities." *Id.* He further noted that it was "not likely [Petitioner] would have finished overhead sanding and moving of the ladder if this was an acute injury[,]" and

that he believed that Petitioner "would have had immediate onset of pain, that would be severe, that would likely be limiting, given the size and nature of that tear." *Id.* At trial, Petitioner denied playing golf after October 4, 2012, finishing overhead sanding with his right arm after his injury on October 4, 2012 (he used his left arm), or using his right arm at all after the incident.

Ultimately, Dr. Cole opined that Petitioner's right shoulder condition was not causally related to any claimed injury at work. *Id.*

Additional Information

Dr. Cummins authored a narrative report dated February 18, 2013 at Petitioner's request. PX3. Therein, Dr. Cummins summarized his medical treatment of Petitioner and reiterated his recommendations for further treatment including arthroscopic surgery. *Id.* He also opined that Petitioner's right shoulder condition was causally related to his reported work injury based on the history provided by Petitioner and the correlation of that history with Petitioner's physical examinations and MRI findings. *Id.* Dr. Cummins further opined that the treatment rendered thus far and further recommendations made were necessary and related to the reported work accident. *Id.*

Ryan Carney

Mr. Carney testified that he is employed by Respondent as an executive director and has been so employed for approximately one year at the Lake Barrington Woods facility. Mr. Carney was Petitioner's direct supervisor and his duties include handling work accidents and calling in claims to the workers' compensation insurance company.

Mr. Carney testified that that Respondent's handbook requires accidents to be reported, no matter how trivial, to an employee's direct supervisor. He testified that all employees are advised of this policy and they must sign acknowledgement of their receipt of the handbook. He also testified that he discussed safety issues and accident reporting policy with employees, including Petitioner, at meetings.

On October 4, 2012, Mr. Carney testified that he was working and spoke to Petitioner while Petitioner was at the Ft. Wayne location. He testified that he asked Petitioner to come by the Barrington office prior to leaving for his scheduled trip. Mr. Carney testified that he had previously spoken with Petitioner who told him about a planned trip to Michigan for a few days to visit daughter in school and perhaps take part in some golfing. Mr. Carney testified that it was important to have the meeting before Petitioner went on vacation because he was going to be suspended. Mr. Carney testified that he did not tell Petitioner the reason for the meeting.

Mr. Carney testified that Petitioner arrived at the Barrington facility at approximately 1:30 (CST), that he heard Petitioner talking down the hall and that Petitioner had a coffee cup in one hand and paper in the other hand. He also testified that he considers physical discomfort to be shown in facial expressions, coddling of a limb perhaps, or limping. He testified that he did not observe Petitioner showing any outward indication of discomfort or injury; Petitioner appeared to move freely and without pain on October 4, 2012.

Then, Mr. Carney told Petitioner to go into the conference room and they had a meeting that lasted about 30 minutes. At that meeting, Mr. Carney testified that he discussed claims made by another employee that Petitioner had made bigoted remarks towards his subordinates. Mr. Carney testified that Petitioner had an opportunity to speak on the issue. At the end of the meeting, Petitioner was suspended pending an investigation,

he was to remove himself from the property and not allowed back unless directed by Mr. Carney to do so, and he turned over his keys. The next step was that Mr. Carney would contact Petitioner.

Mr. Carney reiterated that Petitioner did not mention any shoulder pain and that he did not observe Petitioner show any outward discomfort. He added that the only time that he saw Petitioner on October 4, 2012 was at this meeting and that Petitioner did not come back to the building to his knowledge.

Mr. Carney testified that his next contact with Petitioner was a few days later when Petitioner sent him an email indicating that he would not be back due to a family emergency. *See* RX5. Mr. Carney testified that Petitioner was not scheduled to work this day and that he did not call Petitioner back to work.

On cross examination, Mr. Carney acknowledged that he did not know whether Petitioner played golf or brought golf clubs with him during the scheduled vacation. He also testified that he did not know how any "golfing" statement made it to Respondent's Section 12 examiner, Dr. Cole.

ISSUES AND CONCLUSIONS

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After reviewing the evidence and due deliberation, the Arbitrator finds on the issues presented at trial as follows:

In support of the Arbitrator's decision relating to Issue (C), whether an accident occurred that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following:

The Arbitrator finds that Petitioner did not sustain an accident that arose out of and in the course of his employment with Respondent as claimed. In light of the record as a whole, the Arbitrator does not find Petitioner's testimony at trial to be credible. Petitioner contradicted himself during testimony on cross examination on important facts ranging from the mechanism of injury to whether he had prior medical treatment or symptoms in the right shoulder after his 1997 surgery. Additionally, Petitioner's memory seemed to fail him on cross examination even when confronted with documents impeaching his initial recitation events on the alleged date of accident or during ensuing events thereafter.

Furthermore, the evidence as posited by Petitioner does not present a plausible series of events given the aforementioned inconsistencies. The Arbitrator does not find it reasonable that Petitioner (an individual who had long ago undergone rotator cuff surgery) sustained a completely unwitnessed, traumatic rotator cuff tear at a long-term care facility when he fell off a ladder after which he completed overhead sanding work and moved a large ladder then drove approximately 200 miles from Ft. Wayne, Indiana to a car dealership and then to Barrington, Illinois and sat through a meeting where he was accused of making bigoted remarks and then suspended followed by two six hour commutes to/from northern Michigan during which he drove with his knee and then simply maintained his physical composure until his wife forced him to seek medical attention five days later on October 9, 2012.

Given this chain of events, the inconsistencies in Petitioner's testimony, the documentary evidence presented contradicting Petitioner's testimony, and the opinion containing in Dr. Cole's report, the Arbitrator finds that Petitioner failed to establish that he sustained a compensable injury arising out of and in the course of his employment with Respondent as claimed. By extension, all other issues are moot and all requested compensation and benefits are denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF DU PAGE)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gloria Savala,
Petitioner,

vs. NO. 11 WC 02331

14IWCC0388

Nestle USA, Inc.,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, medical expenses, prospective medical expenses and notice and being advised of the facts and law affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on June 25, 2013 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

14IWCC0388

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 27 2014

Daniel R. Donohoo

Ruth W. White

Charles J. DeVriendt

o-05/22/14
drd/wj
68

# ILLINOIS WORKERS' COMPENSATION COMMISSION
# NOTICE OF 19(b) DECISION OF ARBITRATOR
8(a)

ZAVALA, GLORIA
Employee/Petitioner

Case# **11WC002331**

14IWCC0388

NESTLE
Employer/Respondent

On 6/25/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0328 LEWIS & DAVIDSON LTD
RICHARD C SHOLLENBERGER JR
ONE N FRANKLIN ST SUITE 1850
CHICAGO, IL 60606

2965 KEEFE CAMPBELL BIERY & ASSOC LLC
NATHAN BERNARD
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

STATE OF ILLINOIS)
)SS.
COUNTY OF DUPAGE)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)/8(a)

Gloria Zavala,
Employee/Petitioner

v.

Nestle,
Employer/Respondent

Case # **11** WC **2331**

Consolidated cases: **none**

14IWCC0388

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Peter M. O'Malley**, Arbitrator of the Commission, in the city of **Wheaton**, on **5/8/13**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☒ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☒ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☒ Is Respondent due any credit?
O. ☐ Other _____

14IWCC0388

FINDINGS

On the date of accident, **6/15/09**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$33,618.32**; the average weekly wage was **$712.25**. (See Arb.Ex#2).

On the date of accident, Petitioner was **49** years of age, ***married*** with **2** dependent children.

Respondent ***has*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$5,078.98** for TTD, **$54,305.58** for medical expenses, **$11,911.95** for short term disability, and **$26,644.33** for long term disability, for a total credit of **$97,940.84**. (See Arb.Ex#2).

Respondent is entitled to a credit of **$0.00** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $473.83 per week for 89-6/7 weeks, from 10/30/09 through 11/9/09, from 2/3/11 through 2/22/11 and from 9/19/11 through 5/8/13, as provided in §8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 6/16/09 through 5/8/13, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $5,078.98 for temporary total disability benefits that have been paid.

Petitioner is entitled to prospective medical expenses in the form of treatment recommended by Dr. John Fernandez. Respondent shall pay the reasonable and necessary medical expenses associated therewith as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of $54,305.58 for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability,-if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

6/21/13
Date

ICArbDec19(b)

JUN 25 2013

STATEMENT OF FACTS:

Petitioner testified as follows regarding her occupational exposure to repetitive trauma and manifestation of disablement on June 15, 2009. She was hired by Respondent in 1996 as a packer. (NT p12) In this position, she was rotated hourly between two tasks: packing boxes and making boxes. (NT pp13-16)

Packing boxes entailed filling small or large boxes with candy as it came down a conveyor. (NT p13) In one hour, she filled 200 to 300 small boxes or 60 to 80 large boxes. (NT pp13-14) She stated the pace was pretty rapid. (NT p15)

Assembling boxes was done by hand and by machine. (NT pp14-15) For hand assembly, she would grab a box, assemble it, tape it, put another box inside and pass it onto a co-worker for packing. (NT pp15-16) For machine assembly, she would grab boxes and feed them into a machine. (NT p16) She still had to open a second box to place into the machine assembled box. (NT p16) She made 60 to 80 boxes by hand in one hour. (NT p16)

After ten years in packing, Petitioner started to notice a condition in her hands. (NT p16) She got a new position catching candy dispensed from a machine in three types of containers, which she described as a tote, a container, and a hopper. (NT pp17, 19, 21)

The totes were about 2 feet long, 1 ½ feet wide and 1 ½ feet high. (NT p18) She would get empty totes from a pallet and put them by the machine. (NT pp17-18) The tote would fill with candy and weighed 30 to 35 pounds. (NT p19) She would stack the full totes on a pallet. (NT pp18-19) She would pile 27 to 36 totes on a pallet. (NT pp18-19) In an eight hour shift she would build 6 to 8 pallets. (NT p19)

The containers were cylinders and looked like plastic garbage cans. (NT p19) She would take them from a pallet and put them next to the machine. (NT pp19-20) When full, the containers weighed 200 to 300 pounds. (NT p20) The containers were rolled on dollies 15 to 50 feet to the scale. (NT p20) She would then roll the dolly to a pallet, grab the containers and drag them off the dolly and onto a pallet. (NT pp20-21)

The hopper would be filled with 1,200 to 1,300 pound of candy. (NT pp21-22) Using a hand jack, she would push the hopper out of the department about 10 to 15 feet. (NT p22) In an eight hour shift she would fill 8 to 13 hoppers. (NT p22)

In this new position, she was responsible for 9 to 12 machines. (NT p23) The machines would clog and the ingredients would stop flowing. (NT pp23-24) When she worked filling hoppers there were hoses running from a hopper on top of the machine which would get clogged. (NT p24) The clogging would occur every three to five minutes. (NT p24) She would bang the hose with a stick to free the clog. (NT p24) She would constantly do this throughout the day using both hands. (NT p24)

On June 15, 2009, Petitioner was banging on a hopper with both hands when the stick she was using slipped forward and she felt a pulling in both arms. (NT p25) Before this occurrence, Petitioner was already experiencing pain, tingling and numbness in her hands and arms. (NT p26) She said when this incident occurred it felt a lot worse and she notified her supervisor, Oscar O'Campo. (NT p26, ArbE1) She said she had been having symptoms for 3 to 4 years but had never previously lost time from work or sought medical attention. (NT p26) Mr. O'Campo completed a report and Petitioner signed it. (NT p26) She was then sent by Respondent to Alexian Brothers Occupational Health Clinic. (PX1, RX2)

On June 19, 2009, she was first seen at Alexian Brothers for numbness, tingling and pain in her hands. (PX1 p2, RX2 p1) The initial note states Petitioner had carpal tunnel syndrome 10 years before. (PX1 p2, RX2 p1) Petitioner testified that she told the doctor that when her child was born her, "hands would swell up and red and I felt tingling." (NT p53) After she gave birth, these symptoms went away. (NT p54) The physical exam was limited to the hands and wrists. (PX1 p3, RX2 p1) On the hand-written notes there is a checklist for parts of the body examined and boxes for the condition of the shoulder, arm, elbow and forearm were checked neither normal nor abnormal. (PX1 p3) The diagnosis was bilateral carpal tunnel syndrome left more than right. (PX1 p4) She was referred for an EMG/NCV.

The EMG/NCV was performed by Dr. Galassi on July 9, 2009, at which time Petitioner provided a history of long-standing and gradually worsening pain in the left wrist accompanied by numbness, tingling and pain. (PX1 p5) She also complained of left elbow pain shooting down and left shoulder pain radiating up to the neck. (PX1 p5) She reported similar symptoms on the right but not as pronounced. (PX1 p5) She stated that she reported an injury in June 2010, when the symptoms significantly worsened. (PX1 p5) He performed a physical examination with positive Tinel's signs bilaterally and pain on palpation of the left ulnar nerve at the elbow. (PX1 p5) The EMG/NCV showed ulnar neuropathy across the left elbow of a moderate degree accompanied by denervating changes, and no evidence of median neuropathy at the wrists. (PX1 p6)

On July 16, 2009, Petitioner returned to Alexian Brothers, where she was referred to Dr. Presant Atluri. (PX1 p11) She also had an initial occupational therapy consult on July 27, 2009, during which Petitioner reported pain of 5 out of 10 at rest and 8 out of 10 with activity. (PX1 p17) She described tingling in all her fingers during the day when active and numbness in all her fingers at night. (PX1 p17) The therapist specifically noted pain in the right wrist with motion. (PX1 p17)

On July 29, 2009, Petitioner was seen by Dr. Atluri for numbness and tingling in the left hand involving all the fingers. (PX2 p2) She also described nocturnal symptoms and symptom aggravation with gripping. (PX2 p2) She described similar but less severe symptoms on the right. (PX2 p2) On physical examination, she had positive Tinel's and digital compression at the left carpal tunnel. (PX2 p2) She was tender in the left cubital tunnel. (PX2 p2) She was also tender at the A1 pulley of the left index and middle fingers without active triggering. (PX2 p2) The diagnoses were left cubital tunnel syndrome and possible carpal tunnel syndrome. (PX2 p3) He injected the left carpal tunnel with cortisone and directed her to return in three weeks. (PX2 pp3-4)

Although she reported symptoms in the right hand and elbow, Dr. Atluri did not examine or make a diagnosis regarding the right hand. (PX2 pp.2-4, 6)

On August 5, 2009, Petitioner returned to Dr. Atluri, who noted no improvement since the injection to the wrist. (PX2 p8) He again limited his examination to the left elbow. (PX 2 pp8, 10) He diagnosed left cubital tunnel syndrome and recommended surgery to decompress the left ulnar nerve. (PX2 p8)

This surgery was eventually performed by Dr. Atluri on October 30, 2009. (PX2 p11) Petitioner was taken off work at that time. (PX2 p13) On follow up of November 3, 2009, Dr. Atluri limited his examination to the condition of the left elbow. (PX1 p13) He referred her for physical therapy and advised her to remain off of work until November 12, 2009. (PX2 p13)

On November 5, 2009, she was seen for therapy evaluation at Alexian Brothers which was limited to the left upper extremity. (PX1 p19) During this evaluation, Petitioner described pain levels of 4 out of 10 at rest and 8 out of 10 with activity. (PX1 p19)
Petitioner returned to work under Dr. Atluri's restrictions on November 10, 2009 (NT p31)

On December 2, 2009, Petitioner returned to Dr. Atluri who again limited his examination to the left elbow. (PX2 p15) He recommended continued therapy and restricted her to work with no use of the left hand/arm. (PX2 p15) Petitioner continued her therapy at Alexian Brothers through December 30, 2009, when she reported pain levels of 6 and 7 out of 10 with rest and activity. (PX1 p27)

On December 30, 2009, Dr. Atluri stated he was concerned about persistent symptoms of left medial elbow pain and numbness in the fingers. (PX2 p17) He recommended continued therapy and restricted her to right-handed work. (PX2 p17) On January 27, 2010, Dr. Atluri noted worsening numbness and tingling. (PX2 p17) He was concerned she was developing motor deficits and recommended a repeat EMG/NCV. (PX2 p21) He again limited her to work only with the right hand. (PX2 p21)

On March 10, 2010, the EMG/NCV was performed. (PX2 p24) The test was positive for right median nerve compression, and probable resolving axonal degeneration and regeneration in the distribution of the distal ulnar nerve on the left. (PX2 p25)

On April 21, 2010, Petitioner returned to Dr. Atluri stating that her symptoms were worsening. (PX2 p28) Dr. Atluri again limited his examination to the left upper extremity. (PX2 p28-29, 31) She described weakness in the hand, pain in the posteromedial elbow, and aggravation of symptoms with use. (PX2 p28) The physical examination noted weakness in small finger abduction, sensitivity and tenderness over the cubital tunnel, and subluxation of the ulnar nerve. (PX2 p28) Dr. Atluri stated he remained concerned about possible motor loss in the hand and offered a revision of the ulnar nerve decompression with an anterior transposition. (PX2 p28)

On June 30, 2010, Dr. Atluri noted his exam was limited to the left upper extremity and that there was no change in symptoms. (PX2 p34) He recommended a second opinion by Dr. Sagerman. (PX2 p34)

On July 9, 2010, Dr. Sagerman also noted his exam was limited to the left elbow and found left ulnar neuritis at the cubital tunnel. (PX2 p37) He stated additional surgery could be performed on an elective basis if symptoms warrant. (PX2 p37) On July 21, 2010, Dr. Atluri again limited his examination to the left elbow and noted Petitioner complained her symptoms were too severe to tolerate and again recommended revision surgery. (PX2 p41)

On November 3, 2010, Petitioner consulted Dr. John Fernandez. (PX4 p4) Unlike Drs. Atluri and Sagerman, Dr. Fernandez did not limit his consultation to the left elbow. (PX4 pp4-6) He noted bilateral hand complaints with a history of gradual onset attributed to work activities at work for 14 years. (PX4 p4) She stated her complaints were bilateral but worse on the left. (PX4 p4) She reported numbness and tingling in the left hand, ring and small fingers and the right hand, thumb, index and middle fingers. (PX5 p4) Neurological findings were paresthesia in the left hand ulnar nerve distribution and right hand median nerve distribution. (PX4 p5) The diagnosis was left elbow residual ulnar neuropathy and right wrist carpal tunnel syndrome. (PX4 p5) Dr. Fernandez recommended revision surgery to the left elbow and work restrictions. (PX4 p6)

On February 4, 2011, Dr. Fernandez performed a left elbow nerve release with subcutaneous transposition. (PX4 p12) Following surgery she was taken off work and began therapy at Athletico. (NT p34, PX4 pp15, 60) (PX p60)

On February 17, 2011, Dr. Fernandez noted improvement in the left elbow. (PX4 p17) He confirmed she had been wearing a long arm splint on the left arm as directed. (PX4 p17) She reporting continued numbness and tingling in the median nerve distribution on the right. (PX4 p17) He again diagnosed right carpal tunnel syndrome. (PX4 p17) He advised her to wear a long arm splint on the left and a short arm splint on the right at

night. (PX4 p18) He released her to work with restrictions of no use of the left arm, and use of the right arm to less than 2 pounds of force. (PX4 p18) Petitioner was provided work within these restrictions on February 22, 2011, and she returned to work. (NT p34)

Petitioner testified that when she returned to work, she was assigned to 5 machines, which repeatedly got clogged. (NT p35) She was also required to put rolls of paper weighing 18 to 20 pounds into the machines. (NT p35) Each machine had to be loaded with paper every 20 to 30 minutes. (NT p35)

On March 24, 2011, Petitioner reported to Dr. Fernandez that she had been performing work only with her right upper extremity. (PX4 p24) On physical examination, he noted hypersensitivity of the surgical site. (PX4 p24) He instructed Petitioner to discontinue use of the left long arm splint. (PX4 p24) Dr. Fernandez imposed light duty restrictions on the left upper extremity of less than 5 pounds and on the right upper extremity of less than 2 pounds, as well as, limited repetitive use and limited use of tools. (PX4 pp24-25)

Petitioner testified that despite the reiteration of her restrictions, her work assignment did not change. (NT p36)

On April 21, 2011, Petitioner returned to Dr. Fernandez reporting near complete resolution of numbness and tingling on the left except at the incision site. (PX4 p29) She reported persistent right hand symptoms in the median nerve distribution. (PX4 p29) She continued to use her right short arm splint. (PX4 p29) Neurological signs of right median nerve abnormality were noted. (PX4 p29) He recommended she receive motion and strength therapy, and continued use of the right short-arm splint. (PX4 p30) He modified work restrictions to light duty capacity and less than 10 pounds of force using the left upper extremity. (PX4 p30)

The final therapy progress note of May 11, 2011, states her last evaluation was on April 20, 2011, and that thereafter physical therapy has been denied by workers' compensation. (PX4 p69) The note stated therapy had not achieved the goal of 25 pound grip strength in the left hand, 50 pound lifting, or ability to return to prior unrestricted work. (PX4 p69)

On May 12, 2011, Petitioner saw Dr. Fernandez and reported that she continued to work in the "light duty" machine operator job as described above. (PX4 p35) He noted resolution of symptoms in the left fingers with numbness along incision site. (PX4 p35) She reported right-sided arm symptoms but considered them to be mild. (PX4 p35) He found positive provocative testing in the right median nerve and negative provocative testing in the left ulnar nerve. (PX4 p35) He recommended formal physical therapy for range of motion, strengthening and massage, and advised she may eventually need surgery for her right wrist. (PX4 p35) He restricted her to work in her current capacity with less than 10 pounds of force with the left upper extremity. (PX4 p36)

On June 14, 2011, Dr. Fernandez noted Petitioner felt better after her surgery but the pain was coming back with use. (PX4 p41) She stated she did not know why her complaints were coming back. (PX4 p41) She described left hand weakness with gripping and electric type pain in the left thumb through middle finger; as well as numbness from the thumb to small finger of the right hand. (PX4 p41) Tinel's tests were positive bilaterally at the elbows and the wrists. (PX4 p41) Dr. Fernandez recommended she restart use of the long arm splint on the left, prescribed prednisone and imposed work restrictions against lifting over 5 – 10 pounds and limiting repetitive use and use of tools. (PX4 p42) He reiterated she may eventually need surgery for the right carpal tunnel syndrome. (PX4 p24)

On July 21, 2011, Petitioner returned to Dr. Fernandez complaining of symptoms in all the fingers of the right hand, most significantly the thumb and index fingers. (PX4 p47) The examination was significant for positive

Tinel's at the right elbow and right wrist and positive Phalen's at the right wrist. (PX4 p47) Dr. Fernandez recommended further conservative treatment prior to surgery and ordered fabrication of a long arm splint with 30 degrees of extension to be worn every night. (PX4 p48) Dr. Fernandez made a new diagnosis of right carpal tunnel syndrome, right elbow cubital tunnel syndrome, EMG positive, active. (PX4 p47) Despite these new findings and diagnoses Petitioner described no new accidents or aggravating factors other than her continued "light duty" work for Respondent as described above. (PX4 p47) Petitioner was given a release to return to work with lifting less than 5-10 pounds bilaterally, minimal repetitive use and minimal use of tools. (PX4 p47-48)

On September 14, 2011, Petitioner was seen at Respondent's request by Dr. Bryan Neal. (RX1) Regarding the onset of symptoms, Dr. Neal claims Petitioner stated she "needed to hit a hopper to get candy to flow as the powder was 'not flowing right.' She was hitting the hopper with a 'long plastic rod.' She does admit that she has done this activity before." (RX1 p9) He claims she described holding the stick "with both hands. During the process of hitting a hopper she stated 'the stick recoiled back' and when it (the stick) 'pulled forward' that was when she felt all her nerves pull." (RX1 p9) He states Petitioner claimed "she injured all four parts then." (RX1 p10) Dr. Neal claims Petitioner denied ever experiencing her conditions prior to June 2009. (RX1 p.10) Dr. Neal conceded that the history he had taken was inconsistent with Petitioner's prior medical records containing the gradual increase of pain in the elbows and wrists up to the time of the episode of June 15, 2009. (RX1 p17)

At the time of the exam, Dr. Neal confirmed Petitioner was removing bad candy from machines at work. (RX1 p9) He also confirms she was still lifting the paper rolls weighing 20 to 21 pounds as described above. (RX1 p9)

Dr. Neal opined that Petitioner's subjective complaints were out of proportion with the objective findings and therefore diagnosed right and left upper extremity pain and paresthesia of unknown etiology. (RX1 p17) Dr. Neal opined that Petitioner's condition was not causally related to or exacerbated by any work injury of June 1, 2009. (RX1 p18) Dr. Neal opined that for any condition she may have sustained on June 1, 2009, she was at maximum medical improvement. (RX1 p18) Finally, Dr. Neal stated Petitioner may be released to return to her regular job without any restrictions. (RX1 p18) He qualified this statement saying "Whereas she may have some symptoms (as she is expected to have when not working), and I do anticipate she may have some, it is not definitely known at this time that she is not able to reasonably endure symptoms and therefore work her regular job." (RX1 p18)

Petitioner testified that Dr. Neal's evaluation lasted 30 minutes. (NT p38) When he arrived, he told her she had to answer all his questions with a yes or a no. (NT p38) She stated "so when I wanted to add things, he said no, yes or no." When asked if she was able to fully describe the work activities she felt contributed to her condition, she stated "No. Because he would not allow me to talk." (NT p39)

On September 15, 2011, Petitioner returned to Dr. Fernandez and reported that she had worn her right upper extremity splint for eight weeks without improvement of her condition. (PX4 p54) Dr. Fernandez recommended and tentatively scheduled right cubital tunnel syndrome decompression with ulnar nerve transposition and right carpal tunnel syndrome decompression. (PX4 p55) Dr. Fernandez continued restrictions of light duty for both upper extremities not to exceed 5 to 10 pounds, limited repetitive use and limited use of tools. (PX4 p55) He specified the limit on repetitive use was less than four hours per day. (PX4 p55)

Prior to September 19, 2011, Petitioner has been provided the above-described work unclogging machines and loading 20-pound paper rolls. (NT p40) On or about September 19, 2011, Petitioner was called into the office by her supervisor and told Respondent would no longer provide "light duty" and for her "to return back to work whenever I was okay."

Respondent initiated payment of TTD which was then terminated on or about October 27, 2011. (NT p41) Thereafter, Petitioner received short term and long term non-occupational disability benefits. (NT p41)

In his deposition on January 5, 2013, Dr. Fernandez opined that Petitioner sustained bilateral cubital tunnel syndrome and carpal tunnel syndrome as a result of occupational exposure of flexion-extension through the elbow, as well as, the wrist, coupled with some element of force, which are all known risk factors in causing or aggravating carpal tunnel syndrome and cubital tunnel syndrome. (PX6 pp19-20) Dr. Fernandez explained that in "the vast majority of cases, carpal tunnel syndrome and cubital tunnel syndrome are progressive, relapsing conditions, which are chronic in nature until we cure them. So I would expect her to require surgery like we recommended. There may be times where she feels better; where she could postpone surgery. But it's my opinion that she does require surgery." (PX6 pp20-21)

Respondent denied the surgery recommended by Dr. Fernandez, and Petitioner proceeded on the present petition under Section 19(b) of the Act.

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT, AND (D), WHAT WAS THE DATE OF THE ACCIDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner claims she sustained carpal tunnel and cubital tunnel injuries due to occupational exposure to repetitive trauma. Petitioner provided unrebutted testimony of her exposure to repetitive trauma while working for Respondent from 1996 to 2009. She described working as a packer for ten years in which she alternated hourly between packing boxes with candy (NT pp12-15), and making boxes to be packed. (NT pp14-16) She packed as many as 300 boxes an hour, or one every 12 seconds, (NT p14) and made as many as 80 boxes an hour, or one every 45 seconds. (NT p15)

Petitioner also provided unrebutted testimony that from 2006 to the date her accident manifested, she moved containers filled with candy. (NT pp17-22) She repeatedly lifted totes by hand which weighed between 30 and 35 pounds. (NT pp18-19) She grabbed and stacked these totes on pallets of 27 to 36 totes each. (NT pp.18-19) She made 6-8 pallets per shift. (NT p19) This means she continuously grabbed, lifted and stacked as many as 288 totes per shift or one tote every 1 2/3rd minutes continuously over an 8 hour period.

She also repetitively pushed containers that weighed 200 to 300 pounds on dollies and then grabbed and dragged the 200 to 300 pound containers off the dollies and onto pallets. (NT pp20-21) She also regularly used a hand jack to push hoppers weighing 1,200 to 1,300 pounds. (NT pp21-22)

Finally, Petitioner described her responsibility to unclog hoses leading into the machines by striking the hose with a stick or plastic rod. (NT pp22-23) She explained that she used both hands to strike the hose and that the hose would clog every three to five minutes. (NT p24)

According to Petitioner, before June 15, 2009, she was already experiencing pain, tingling and numbness in her hands and arms. (NT p26) When she was seen at Alexian Brothers on June 19, 2009, she explained that the occurrence on June 15, 2009, had exacerbated her condition. (RX2 p1) When she was seen on July 9, 2009 for her EMG, she reported pain in both shoulders, elbows and wrists, but that the occurrence significantly worsened the symptoms in her left hand. (PX1 p5) When she first saw Dr. Atluri, she stated that the onset of symptoms began several years before but had progressively worsened and become quite severe. (PX2 p2) When she first saw Dr. Fernandez, Petitioner explained her symptoms began gradually and she attributed them to work activities as a machine operator for 14 years with Respondent. (PX4 p4)

Petitioner testified that on June 15, 2009, a specific aggravation of symptoms in the left wrist occurred. (NT p25) She was holding a stick with both hands and banging a hose which was clogged. (NT p25) The stick slipped and went forward, and she felt a pulling in both arms followed by pain, tingling and numbness in both arms and wrists. (NT p26) This was the same type of pain she had been feeling for 3 to 4 years. (NT p26)

Prior to the incident of June 15, 2009, Petitioner had never received treatment or missed time from work because of this condition.

In his report, Respondent's medical expert, Dr Neal, claims he carefully questioned Petitioner about the onset of her symptoms and that she claimed never to have had symptoms in her arms or wrists prior to the incident of June 15, 2009. (RX1 p17) He claims Petitioner told him all her injuries were due solely to a single occurrence on June 15, 2009, when she hit a hopper with a rod. (RX1 p9) Petitioner testified that she was not able to explain her injury to Respondent's medical expert, because he only allowed her to answer his questions with a yes or no. (NT p38)

The Arbitrator finds Petitioner to be a credible witness and finds as fact that she performed the described highly repetitive work activity requiring grabbing, lifting, pushing and striking. In light of Petitioner's credible testimony and corroborating treating records, the Arbitrator questions Dr. Neal's contention that Petitioner claimed all her symptoms began on the day of the June 15, 2009, incident.

The Arbitrator further finds that while performing highly repetitive work for Respondent, Petitioner gradually developed symptoms of pain, numbness and tingling in her arms and hands. Due to these symptoms, which worsened after June 15, 2009, she sought medical care and was restricted to light work.

Based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner proved by a preponderance of the credible evidence that she sustained repetitive trauma type injuries to her right and left upper extremities arising out of and in the course of her employment and that said injuries manifested themselves on or about June 15, 2009.

WITH RESPECT TO ISSUE (E), WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

In light of the above finding as to accident (issue "C", supra) and given Petitioner's unrebutted testimony to the effect that she notified her supervisor of her symptoms on June 15, 2009 and that she was subsequently treated for these symptoms at the company clinic on June 19, 2009, the Arbitrator finds that Petitioner provided proper and timely notice of the accident pursuant to §6(c) of the Act.

WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

In his initial visit of November 3, 2010, Dr. Fernandez was advised by Petitioner of a gradual onset of hand and arm symptoms while working as a machine operator for 14 years. (PX4 p4) She stated her complaints were bilateral but worse on the left. (PX4 p4) In his testimony, Dr. Fernandez opined that Petitioner sustained bilateral cubital tunnel syndrome and carpal tunnel syndrome as a result of occupational exposure of flexion-extension through the elbow, as well as, the wrist, coupled with some element of force, which are all known risk factors in causing or aggravating carpal tunnel syndrome and cubital tunnel syndrome. (PX6 pp19-20)

Prior to Dr. Fernandez, Dr. Atluri limited his examination and treatment of Petitioner to the left elbow. At the conclusion of this treatment, his recommendation was additional surgery to revise the cubital tunnel decompression. The Arbitrator notes that Dr. Atluri became Petitioner's surgeon only after a referral by the clinic to which she had been referred by Respondent, and that Dr. Atluri never offered any opinions regarding the cause of her condition. Nonetheless, he communicated with the workers compensation insurer to secure authorization for treatment. (PX2 p32)

As to this issue, Respondent provided the report of Dr. Neal. As stated above Dr. Neal considered only a history of a single episode injury of June 15, 2009, on his causal connection opinion. (PX1 p18) As stated above, the Arbitrator rejects Dr. Neal's description of accident. Dr. Neal offers no opinion as to whether the exposure to repetitive trauma, found to have occurred, was a cause of Petitioner's condition.

Based on the above, and the record taken as a whole, and in light of the Arbitrator's determination as to accident (issue "C", supra), the Arbitrator finds that Petitioner's current condition of ill-being is causally related to the accident on or about June 15, 2009. Along these lines, the Arbitrator finds the opinions of Dr. Fernandez to be more persuasive than those offered by Respondent's examining physician, Dr. Neal..

WITH RESPECT TO ISSUE (G), WHAT WERE THE PETITIONER'S EARNINGS, THE ARBITRATOR FINDS AS FOLLOWS:

While this issue was originally in dispute (See Arb.Ex.#1), the parties subsequently prepared an agreed stipulation setting forth an agreed salary of $33,618.32 for the year preceding the injury and an average weekly wage of $712.25. (See Arb.Ex.#2).

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

As to this issue, Petitioner presented the records and testimony of Dr. Fernandez that she had positive Tinel's testing at the right elbow and wrist and positive Phalen's testing at the right wrist. (PX4 pp47-48, 54-55; PX6 pp16-19) Based upon these findings, Dr. Fernandez diagnosed right cubital and carpal tunnel syndrome. (PX4 pp47-48, 54-55; PX6 pp16-19) For this condition, Dr. Fernandez recommended surgeries to decompress the cubital and carpal tunnel with transposition of the ulnar nerve. (PX4 pp47-48, 54-55; PX6 pp16-19)

Respondent offered the opinion of Dr. Neal. Dr. Neal again confined himself to stating only that any condition Petitioner may have sustained in June 2009, had reached maximum medical improvement.

Based upon the above, and the record taken as a whole, as well as the Arbitrator's determination as to accident and causation (issues "C" and "F", supra), the Arbitrator finds that Petitioner is entitled to prospective medical are and treatment as recommended by treating surgeon Dr. Fernandez, including surgery to decompress the cubital and carpal tunnel syndrome. As a result, Respondent shall pay the reasonable and necessary medical expenses associated therewith pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act.

WITH RESPECT TO ISSUE (L), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner provided documentation that following the surgery of October 30, 2009, Petitioner was taken off work through November 10, 2009. (PX2 p13, NT 31) No opinion was offered by Respondent other than the opinion of Dr. Neal, that this surgery was reasonable and necessary. (RX1 p18)

Petitioner also provided documentation that from the surgery on February 4, 2011, Petitioner was taken off work through February 22, 2011. (PX4 pp15, 22; NT p34) No opinion was offered by Respondent other than the opinion of Dr. Neal, that this surgery was reasonable and necessary. (RX1 p18)

Finally, Petitioner provided the records of Dr. Fernandez on September 15, 2011, in which he imposed restrictions of light duty for both upper extremities not to exceed 5 to 10 pounds, limited repetitive use and limited use of tools. (PX4 p55) Petitioner's testimony is unrebutted that Respondent refused to provide work within these restrictions after September 18, 2011. (NT p40)

Respondent provided the above opinion of Dr. Neal that Petitioner may be released to return to her regular job without any restrictions. (RX1 p18) Dr. Neal qualified this statement saying "Whereas she may have some symptoms (as she is expected to have when not working), and I do anticipate she may have some, it is not definitely known at this time that she is not able to reasonably endure symptoms and therefore work her regular job." (RX1 p18)

Based upon the above, and the record taken as a whole, as well as the Arbitrator's determination as to accident and causation (issues "C" and "F", supra), the Arbitrator finds that Petitioner was temporarily totally disable from 10/30/09 through 11/9/09, from 2/3/11 through 2/22/11 and from 9/19/11 through 5/8/13, for a period of 89-6/7 weeks. Along these lines, the Arbitrator finds the opinions of Dr. Fernandez to be more persuasive than those offered by Respondent's examining physician, Dr. Neal.

WITH RESPECT TO ISSUE (N), IS THE RESPONDENT DUE ANY CREDIT, THE ARBITRATOR FINDS AS FOLLOWS:

While this issue was originally in dispute (See Arb.Ex.#1), the parties subsequently prepared an agreed stipulation wherein it was agreed that Respondent would be entitled to a credit in the amount of $5,078.98 for TTD benefits, $54,305.58 for medical expenses, $11,911.95 for short term disability and $26,644.33 for long term disability. (See Arb.Ex.#2).

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Terry Hartwig,
Petitioner,

vs. NO. 13 WC 05019

Modern Drop Forge,
Respondent.

14IWCC0389

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary total disability, medical expenses, and prospective medical expenses and being advised of the facts and law affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on July 17, 2013 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $15,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 2 7 2014

Daniel R. Donohoo

Ruth W. White

Charles J. DeVriendt

o-05/22/14
drd/wj
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) DECISION OF ARBITRATOR

HARTWIG, TERRY
Employee/Petitioner

Case# **13WC005019**
12WC026541

MODERN DROP FORGE
Employer/Respondent

14IWCC0389

On 7/17/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1067 ANKIN LAW OFFICE LLC
SCOTT GOLDSTEIN
162 W GRAND AVE SUITE 1810
CHICAGO, IL 60654

0766 HENNESSY & ROACH PC
MICHAEL GEARY
140 S DEARBORN 7TH FL
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Terry Hartwig
Employee/Petitioner

v.

Modern Drop Forge
Employer/Respondent

Case # **13WC5019**

Consolidated case: **12WC26541**

14IWCC0389

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Milton Black**, Arbitrator of the Commission, in the city of **Chicago**, on **June 19, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other: Severance

FINDINGS

On the date of accident, **January 23, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned **$64,480.00**; the average weekly wage was **$1,240.00**.

On the date of accident, Petitioner was **52** years of age, ***married*** with **0** dependent children.

Respondent ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$2,487.30** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$2,487.30**.

Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

Respondent shall be given a credit of **$2,487.30** for TTD, **$0** for TPD, and **$0** for maintenance benefits, for a total credit of **$2,487.30**.

Respondent shall pay Petitioner temporary total disability benefits of **$826.67**/week for **16 3/7^{ths}** weeks, commencing **February 25, 2013** through **June 19, 2013**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **January 23, 2013** through **June 19, 2013**, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of **$2,487.30** for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of **$1,652.00** to **Advocate Occupational Health**, and **$2,690.00** to **Orland Park Orthopedics**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall authorize and pay for a right shoulder MRI under anesthesia in a hospital setting, as recommended by Dr. Blair Rhode.

Case number 12 WC 26541 is severed from case number 13 WC 5019

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Milton Black

Signature of Arbitrator

July 17, 2013
Date

JUL 17 2013

FACTS

On January 23, 2013 Petitioner was working for Respondent as a parts inspector. Petitioner testified that the majority of the time he worked as a hammer man. However, on that date he was working as a parts inspector, because Respondent was providing him light duty as a result of a prior hip condition. Inspectors look for the buildup of scale steel or slag on a part. If a part has scale, it must be rejected, because Respondent did not want bad parts to go to the public. Petitioner noticed that a part in the box had scale on it. He reached down with both hands to grab it and to pull it out of the box. However, the part was stuck in the box among the other parts. Petitioner exerted himself to remove the, and in the process he noticed pain in his right shoulder, left shoulder, and neck. Petitioner identified photographs showing the actual shape of the part and showing his work station (PX1A; PX1B; PX1C). The incident was documented by Respondent in a "Department Injury Log" (PX4).

Respondent sent Petitioner for treatment to Advocate Occupational Health on January 25, 2013 (PX2). Petitioner was provided a light duty restriction by Advocate Occupational Health and began therapy through that facility. Petitioner then chose to treat with an orthopedic physician, Dr. Blair Rhode, at Orland Park Orthopedics. Petitioner saw Dr. Rhode on February 25, 2013 (PX1, Dep. Exhibits 1 and 3). A right shoulder MRI was prescribed, and. Dr. Rhode took Petitioner off work. Petitioner testified that he attempted to obtain the MRI but the MRI facility could not get an accurate MRI reading, partially due to his large size. Petitioner testified that he is claustrophobic, and it is difficult for him to undergo an MRI due to him having to remain in a confined setting for a period of time. He testified that in the past he has had MRI's done under anesthesia in a hospital setting and that has worked well for him. The MRI in the hospital setting has not been authorized. The Petitioner remains in an off work status. He has not received temporary total disability payments since they were stopped on February 24, 2013. Additionally, he is waiting for authorization for his right shoulder MRI under

anesthesia at a hospital.

Dr. Rhode testified at a deposition that it is reasonable for the Petitioner to have the MRI in the hospital setting (PX1, p15). Dr. Rhode testified that his future medical needs include the MRI (PX1, p30). Dr. Rhode 's May 24, 2013 post deposition medical records indicate that he is waiting for authorization for the right shoulder MRI with sedation (PX3).

Petitioner was examined by Dr. William Heller on March 13, 2013, at Respondent's request. Dr. Heller felt the Petitioner had sprain/strain type injuries. Petitioner testified that he did not give Dr. Heller the history recited in his report. Dr. Heller testified at a deposition that a right shoulder MRI with sedation would be reasonable treatment for Petitioner.

Peggy Cooper testified for Respondent. She testified that Petitioner was working under her supervision at the time of the alleged work injury. She testified that the "Department Injury Log" is prepared close in time to a reported injury to ensure accuracy. She testified that she was not observing Petitioner at the time of the alleged occurrence.

ACCIDENT

Petitioner was the only witness to the occurrence. Petitioner testified credibly that he was injured attempting to remove a metal part that was stuck among other parts in a box. His testimony was corroborated by a contemporaneous Respondent accident report form. The medical records are consistent.

Based upon the foregoing, the Arbitrator finds that on January 23, 2013 Petitioner sustained an accident that arose out of and in the course of his employment.

CAUSATION

Respondent's defense on this issue is premised upon accident, which has been resolved in favor of Petitioner.

Therefore, the Arbitrator finds that Petitioner's current condition of ill being is causally related to the accident.

PAST MEDICAL

Respondent's defense on this issue is premised upon accident, which has been resolved in favor of Petitioner.

Therefore, the Arbitrator finds that Petitioner is entitled to the claimed unpaid medical expenses.

PROSPECTIVE MEDICAL

Respondent's defense on this issue is premised upon accident, which has been resolved in favor of Petitioner.

Therefore, the Arbitrator finds that Petitioner is entitled to the requested prospective medical treatment.

TEMPORARY TOTAL DISABILITY

Respondent's defense on this issue is premised upon accident, which has been resolved in favor of Petitioner.

Therefore, the Arbitrator finds that Petitioner is entitled to the claimed temporary total disability benefits.

MOTION TO SEVER

Case number 12WC26541 was previously consolidated with case number 13 WC 5019. Petitioner has filed a motion to sever in order to separately proceed with this emergency matter. Consolidation for docketing is not consolidation for trial.

Therefore, case number 12 WC 26541 is severed from case number 13 WC 5019.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Garabed Damarjian,
Petitioner,

vs. NO: 10 WC 08037

14IWCC0390

City of Chicago,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of nature and extent of Petitioner's permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 8, 2013 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

14IWCC0390

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED:

MAY 27 2014

Daniel R. Donohoo

Ruth W. White

Charles J. DeVriendt

o-05/22/14
drd/wj
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DAMARJIAN, GARABED
Employee/Petitioner

Case# **10WC008037**

CITY OF CHICAGO
Employer/Respondent

14IWCC0390

On 10/8/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1702 GRAZIAN & VOLPE PC
VOLPE, RICHARD S
5722 W 63RD ST
CHICAGO, IL 60638

0010 CITY OF CHICAGO
MICHELLE BRYANT
30 N LASALLE ST 8TH FL
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
X None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Garabed Damarjian
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **10** WC **8037**

Consolidated cases: **D/N/A**

14IWCC0390

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly C. Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **9/25/13**. By stipulation, the parties agree:

On the date of accident, **1/31/09**, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

On this date, Petitioner sustained an accident that arose out of and in the course of employment.

Timely notice of this accident was given to Respondent.

Petitioner's current condition of ill-being is causally related to the accident.

In the year preceding the injury, Petitioner earned $**$53,508.00**, and the average weekly wage was $**1,029.00**.

At the time of injury, Petitioner was **61** years of age, ***married*** with **0** dependent children.

Necessary medical services and temporary compensation benefits have been provided by Respondent.

Respondent shall be given a credit of $**3,526.04** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**3,526.04**.

After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury, and attaches the findings to this document.

ORDER

Respondent shall pay Petitioner the sum of **$617.40**/week for a further period of **15** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **3% loss of use of the person as a whole**.

Respondent shall pay Petitioner compensation that has accrued from **1/31/09** through **9/25/13**, and shall pay the remainder of the award, if any, in weekly payments.

RULES REGARDING APPEALS Unless a Petition for Review is filed within 30 days after receipt of this decision, and a review is perfected in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Molly C Mason
Signature of Arbitrator

10/8/13
Date

OCT 8 - 2013

14IWCC0390

Arbitrator's Findings of Fact

Nature and extent is the sole disputed issue. Arb Exh 1.

Petitioner, who was 66 years old as of the hearing, testified he has worked for Respondent for 23 years. He is a bridge operator assigned to a bridge on Lake Shore Drive near Navy Pier. In addition to raising and lowering bridges, he does timekeeping and scheduling.

The parties agree Petitioner sustained a work accident on January 31, 2009. Arb Exh 1. Petitioner testified he was injured when he fell down some stairs that lead to the bridge house where he works. Only Respondent employees can access these stairs. The stairs are shown in photographs marked PX 3 and 4. Petitioner testified he took these photographs at some point after the accident.

Petitioner testified that, on January 31, 2009, the stairs in question were covered with snow and ice. He was descending the stairs in order to get something he needed for work when a metal strip on the edge of one stair came loose, causing him to lose his footing and fall. [The photograph marked as PX 4 shows the stair in question; the adjacent stairs have metal strips at their edges.]

Petitioner testified he called his supervisor, James Frobes, and reported the accident. Frobes came to the bridge house and took Petitioner to the Emergency Room at Mercy Hospital.

The Emergency Room records (PX 1) reflect that, four hours prior to arriving at the hospital, Petitioner was descending stairs when a metal plate on the stairs "slipped off," causing Petitioner to fall and "slip down the stairs on [his] back." Petitioner complained of low back pain and difficulty walking. The examining physician noted tenderness and swelling over the central sacrum. Lumbar spine X-rays showed no fractures or dislocations with the interpreting radiologist noting that the sacrum was "not well evaluated" and that a sacral MRI could be ordered. Petitioner was given Flexeril and Toradol, along with a single crutch to assist with walking. Petitioner was instructed to follow up with MercyWorks in two days. PX 1.

On February 3, 2009, Petitioner sought follow-up care at MercyWorks, where he saw Dr. Anderson. Dr. Anderson noted that Petitioner was descending stairs four days earlier when a "metal plate slipped," causing him to fall down four to five steps. Dr. Anderson also noted that Petitioner had discontinued the Toradol due to stomach upset but was taking Advil along with the Flexeril.

On examination, Dr. Anderson noted tenderness but no bruising or swelling at the left sacrum at the S2 level to the coccyx. He also noted negative straight leg raising.

Dr. Anderson diagnosed a contusion of the sacral coccyx. He instructed Petitioner to stay off work, begin heat therapy, continue the Flexeril and start Motrin. He provided Petitioner with literature concerning home exercises. He instructed Petitioner to return in two weeks. PX 2.

Petitioner returned to MercyWorks on February 10, 2009 and again saw Dr. Anderson. Petitioner complained of persistent pain in the sacrum with sitting, walking and change of position. He denied any radicular symptoms. On examination, Dr. Anderson again noted tenderness at the left sacrum and negative straight leg raising. He released Petitioner to light duty, with no use of ladders and no repetitive bending, stooping or squatting. He instructed Petitioner to continue Ibuprofen and heat therapy. PX 2.

At the next visit, on February 16, 2009, Dr. Anderson noted a complaint of persistent left buttock pain. He described the X-ray as negative. He prescribed Motrin and Soma and instructed Petitioner to begin physical therapy. He continued the previous work restrictions. PX 2.

Petitioner attended therapy on four occasions before returning to Dr. Anderson on March 2, 2009. Dr. Anderson noted that Petitioner reported some improved mobility and admitted to less frequent low back pain. He also noted that Petitioner complained of some transient numbness in his left upper leg. He again noted tenderness at the left sacrum and negative straight leg raising. He instructed Petitioner to continue restricted duty and therapy. PX 2. Petitioner continued attending therapy thereafter.

At the next visit, on March 9, 2009, Dr. Anderson again noted improvement but indicated that Petitioner "still has some left leg pain that goes into left thigh." He also noted "questionable tingling into left foot." He described straight leg raising as "questionably positive" on the left. He recommended a lumbar spine MRI and released Petitioner to full duty.

At the hearing, Petitioner could not recall undergoing a MRI scan. The Mercy Hospital records reflect that he underwent a spinal MRI on March 26, 2009 but the MRI report is not in evidence.

On March 30, 2009, Dr. Anderson noted that Petitioner was "doing a little better." Dr. Anderson indicated that the MRI report showed "multi-level degenerative disc disease, most significant at L3-L4 level" and no central canal stenosis or neural foraminal narrowing. Dr. Anderson described his examination findings as unchanged. He prescribed Motrin and additional therapy. He again released Petitioner to full duty. The records in PX 2 reflect that Petitioner attended five more therapy sessions before returning to Dr. Anderson on April 27, 2009. On that date, Dr. Anderson noted that Petitioner was still experiencing left-sided lower back pain but reported better function. He also noted that the therapy records reflected significant progress. [The therapy records are not in evidence.] On examination, he noted primary tenderness on the left at L4-S1 and negative straight leg raising. He instructed

Petitioner to stop Ibuprofen, start Mobic and continue his home exercises. He again released Petitioner to full duty. He instructed Petitioner to return to him on June 8, 2009. There is no evidence indicating that Petitioner returned to MercyWorks on that date.

At the hearing, Petitioner testified he still experiences low back pain and numbness in his feet. He denied having any similar symptoms prior to the accident. He asked his primary care physician about his back condition at one point. [The primary care physician's records are not in evidence.] He continues to take over-the-counter Ibuprofen.

Under cross-examination, Petitioner testified he resumed his regular job once Dr. Anderson released him to full duty. He was still performing that job as of the hearing. He is not subject to any restrictions. His work schedule and salary have not changed. He could not recall whether he ever asked Dr. Anderson to refer him to a specialist. He continues to perform home exercises. He takes Ibuprofen on waking and when he "walks too much." He did not return to MercyWorks on June 8, 2009, as instructed, because the treatment that Dr. Anderson prescribed did not help him. He has not reinjured his lower back or coccyx since the accident.

Respondent did not call any witnesses or offer any documentary evidence.

Arbitrator's Credibility Assessment

The Arbitrator found Petitioner to be highly credible. Petitioner repeatedly stated he did everything he was instructed to do, treatment-wise, but did not improve.

What is the nature and extent of the injury?

Before turning to the issue of permanency, the Arbitrator notes that Respondent took causation out of dispute once Petitioner finished testifying. Arb Exh 1.

There is no dispute that Petitioner fell down concrete stairs while working, striking his lower back against the stairs when he landed. This fall resulted in an injury to the sacral coccyx that remains symptomatic despite conservative care. Petitioner underwent lumbar spine X-rays a few hours after the accident. The radiologist who interpreted these X-rays indicated he had difficulty evaluating the sacrum. He suggested that Petitioner undergo a sacral MRI but there is no evidence this particular study was performed. Based solely on the X-rays, Petitioner was diagnosed with a sacral coccyx contusion. Petitioner also developed left-sided radicular symptoms after the fall. A lumbar spine MRI showed some degree of degeneration at L3-L4. The injury did not prevent Petitioner from resuming full duty but he credibly testified he still experiences low back pain and some numbness. As of the hearing, he was still taking Ibuprofen on a regular basis for these symptoms. Based on the foregoing, the Arbitrator finds that Petitioner is permanently partially disabled to the extent of 3% loss of use of the person as a whole, or 15 weeks of compensation, under Section 8(d)2 of the Act.